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Factors affecting psychological help-seeking in men

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Thesis submitted in partial fulfilment of the requirements for the degree of
Doctor of Clinical Psychology

Coventry University, Faculty of Health and Life Sciences &

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List of Abbreviations

BPS	British Psychological Society
CSA	Child Sexual Abuse
GRC	Gender Role Conflict
IAPT	Improving Access to Psychological Therapies
MHL	Mental Health Literacy
MHP	Mental Health Practitioner
SA	Sexual Abuse
TPB	Theory of Planned Behaviour

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Declaration

This thesis has been written for submission as partial fulfilment of the requirements for the Clinical Psychology Doctorate Programme of Coventry University and the University of Warwick. It has not been submitted for a degree at any other university. This thesis was conducted under the academic supervision of Dr Tom Patterson and Dr Anthony Colombo. Apart from these collaborations this thesis is my own work. The nominated journals for publication of chapters 1 and 2 are the Sexual Abuse: A Journal of Research and Treatment and The Journal of Men's Studies respectively (see Appendix A & D for instructions to authors). Authorship of papers will be shared with the above supervisors where appropriate.

Word count (excluding tables, figures, references and appendices)

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Summary of Chapters

This thesis focuses on the psychology of men, and in particular the factors that are associated with their disclosure and help-seeking experiences in two particular contexts: following sexual abuse and when experiencing a psychological difficulty. This thesis consists of three chapters:

Chapter 1 is a systematic review of the literature, investigating the barriers to disclosure and help-seeking for male survivors of sexual abuse. Five barriers were identified: unwillingness to acknowledge the abuse, the nature of the abuse and abuser factors, perceptions of sexual orientation, stigma and shame, and mistrust of others and services. These barriers are discussed within the context of masculinity. Clinical implications are discussed, such as the importance of training in the sexual abuse of men for professional staff groups.

Chapter 2 is a vignette based empirical study which explores factors associated with help-seeking for psychological difficulties in men. The study used the theory of planned behaviour as a guiding framework in order to test a number of hypotheses. Data were collected using an online survey and participants were men aged 18-65, living in the UK, who were recruited via social media. Perceived behavioural control and attitudes toward seeking professional psychological help were significant variables within the theory of planned behaviour model. Men were most likely to endorse seeking help from their intimate partners and GPs and least likely from helplines and religious leaders. Clinical implications are discussed and areas of future research recommended.

Chapter 3 is a reflective paper which discusses how the topic of the thesis originated. This paper reflects on the experiences of being a male trainee clinical psychologist in a predominantly female profession, as well as in relation to carrying out research on male psychology. The paper concludes with final thoughts about how the work started in this thesis can be continued post-qualification.

Chapter 1: Barriers to disclosure in male survivors of sexual abuse: A systematic review of the literature

Prepared for submission to **Sexual Abuse: A Journal of Research and Treatment** (see Appendix A for author guidelines).

Chapter word count: 8,025 (excluding tables, figures and references)

1.1 Abstract

The present review aimed to critically evaluate the empirical evidence on the barriers to disclosure and help-seeking for male survivors of sexual abuse. A systematic search of the literature, including five databases and citations, identified 20 studies which met the criteria for inclusion. Five salient barriers to disclosure and help-seeking were identified: unwillingness to acknowledge the abuse, the nature of the abuse and abuser factors, perceptions of sexual orientation, stigma and shame, and mistrust of others and services. These findings are discussed within the context of masculinity and male rape myths, which appeared to permeate all five barriers identified in the current review. Important clinical implications include a need for more training to be provided for staff on the sexual abuse of men and boys. A need for further research on facilitators to disclosure and help-seeking for male survivors of sexual abuse was also identified.

Key words: sexual abuse; disclosure; help-seeking; men; male

1.2 Introduction

1.2.1 Sexual Abuse

A number of different terms and definitions are used to refer to 'sexual abuse' (SA) and types of SA in the literature, including, sexual assault, sexual victimisation, sexual coercion, sexual violence, rape, and incest (Arttime, McCallum, & Peterson, 2014). This paper will consider SA in its broadest sense, as "any non-consensual sexual acts perpetrated against a man" (Isely & Gehrenbeck-Shim 1997, p.160), and child sexual abuse (CSA) as any form of sexual contact which occurs "before the age of 18 in which the perpetrator was at least five years older" (Arttime et al., 2014, p.313), or as "forced sexual contact with a perpetrator of any age before 18" (Arttime et al., 2014, p.313).

1.2.2 Sexual Abuse of Males

There are a number of myths surrounding the sexual abuse of males (Watkins & Bentovim, 2000). These include that males are hardly ever sexually abused, that males are only abused by gay men, and that males who have been sexually abused are less psychologically affected than females. The evidence-base in relation to these myths will now briefly be considered.

1.2.2.1 Rates of Sexual Abuse in Males

Historically, limited statistical evidence on male SA perpetuated the belief that the phenomenon itself did not occur frequently (King, Coxell, & Mezey, 2000). The difficulty in obtaining accurate data on male SA centres on problems with the legal definition of the offence. For example, male rape was not formally recognised by English law until 1994 (King & Woollett, 1997), and by American law until 2012 (Arttime, McCallum, & Peterson, 2014; Department of Justice, 2012). Sexual abuse has been framed as an offence against women within the larger violence against women literature by activists and feminist scholars (Young, Pruett, & Colvin, 2016).

In the absence of formal crime statistics, a number of research studies have attempted to gauge the prevalence of male SA within the general population. With variations in methodology, definitions of SA, populations studied and time frames considered they have led to disparities across studies (Peterson, Voller, Polusny, & Murdoch, 2011), as the findings are revealing. For example, research suggests that between 5% and 15% of men in the general population report having been victims of childhood sexual abuse (Briere & Elliott, 2003; Finkelhor, Hotaling, Lewis, & Smith, 1990; World Health Organisation, 2006). In adulthood this figure is thought to be up to 7% (Elliott, Mok & Briere, 2004), and as high as 17% in gay or bisexual men (Heidt, Marx, & Gold, 2005).

However, until recently, male survivors have not been considered a research priority (Easton, Saltzman, & Willis, 2014), which has “rendered them almost invisible” in the literature (Gagnier & Collin-Vézina, 2016, p. 222). Even when male survivors are included in studies, the numbers are often too small to separate the data based on gender (Gagnier & Collin-Vézina, 2016; Sorsoli, Kia-Keating, & Grossman, 2008).

1.2.2.2 The Sexual Abuse of Males by Females

In their study, Cook, Morisky, Williams, Ford, and Gee (2016) found that 6% of a sample of 8108 US men who completed a national survey reported being the victim of forced sex by a female perpetrator. In addition, Krahe, Scheinberger-Olwig, and Bieneck (2003) conducted two studies and reported a prevalence rate of 25.1% and 30.1% respectively. Kissing/petting was the most frequently reported unwanted sexual activity, followed by sexual intercourse and oral sex. Krahe, Waizenhofer, and Moller (2003) found that 9.3% of women in their study admitted to having used aggressive methods (such as exploiting a man’s incapacitated state, verbal pressure, and physical force) to coerce a man into sexual activities.

Research by Struckman-Johnson and Struckman-Johnson (1992) on college students has found that participants were more likely to accept male rape myths (such as that men cannot be on the receiving end of sexual abuse), where the rape perpetrator was female rather than male. Beliefs in

these myths have also been found among professionals. For example, Donnelly and Kenyon (1996) found that male law enforcement officers did not acknowledge that men could be victims of sexual abuse, and female crisis centre workers believed women almost never committed sexual abuse and that men are rarely victims.

1.2.2.3 Psychological and Behavioural Effects of SA in Male Survivors

Sexual abuse can have numerous long term psychological effects on men such as low self-esteem, depression, self-blame, guilt, anger, anxiety, sleep disorders, trauma, and self-harm (Briere, Evans, Runtz, & Wall, 1988; Frazier, 1993; King et al., 2002; Romano & De Luca, 2001), and these can last into old age (Talbot et al., 2009). One consequence of these psychological effects can be behavioural changes across the lifespan. Men and boys may present with aggression, criminal activity, drug and alcohol use, school truancy, running away, family or marital problems, violence, and suicide attempts (Amos et al., 2008; Butler, Donovan, Fleming, Levy, & Kaldor, 2001; Darves-Bornoz, Choquet, Ledoux, Gasquet, & Manfredi, 1998; Dube et al., 2005; Garnefski & Arends, 1998). The number of incidents of SA experienced by men, along with being injured by a caregiver, and exposure to other trauma has been linked with higher levels on a number of these mental health symptoms (Banyard, Williams, & Siegel, 2004).

Additionally, numerous studies on men have found a link between experiencing sexual abuse in childhood with an increased risk of being sexually victimised in adulthood (Coxell, King, Mezey, & Gordon, 1999; Desai, Arias, Thompson, & Basile, 2002). Men with a history of experiencing SA are more likely to have higher rates of sexual risk-taking behaviours, as well as being more likely to be diagnosed with a sexually transmitted infection (de Visser, Smith, Rissel, Richters, & Grulich, 2003; Kalichman & Rompa, 1995; Kalichman et al., 2001).

1.2.3 Disclosure and Help-Seeking

The terms “disclosure” and “help-seeking” are often used interchangeably in the literature (Campbell, Greeson, Fehler-Cabral, & Kennedy, 2015). However, “disclosure” is more commonly used to describe the process of informing someone about the abuse, usually an informal source such as a friend or family member. “Help-seeking” is typically used to describe the process of informing a formal help provider, such as the police or a doctor (Campbell et al., 2015). For the purpose of this paper both terms will be used interchangeably to refer to the process of telling another about the abuse regardless of the relationship between the survivor and the person they tell.

Survivors of sexual abuse usually wait many years or even decades until they disclose, with up to 70% of adults reporting they did not tell anyone

during childhood about being sexually abused (Alaggia, 2010; London, Bruck, Ceci, & Shuman, 2005; O'Leary & Barber, 2008), even though they may have been experiencing considerable distress (Romano & De Luca, 2001). Disclosure can be conceptualised as a complex and life-long process, rather than a discrete one-off event (Gagnier & Collin-Vézina, 2016; Hunter, 2011).

No matter at what point in the lifespan sexual abuse is disclosed it is often a complex and painful step to take (Ahrens, Standsell & Jennings, 2010). Disclosing SA is usually critical to securing treatment or early intervention (Sorsoli, Kia-Keating, & Grossman, 2008), and prompt disclosure has also been found to moderate symptom severity and reduce the likelihood of further victimisation (Kogan, 2004).

1.2.4 Disclosure and Help-Seeking in Men

Although disclosing and seeking help for SA is complex, painful and difficult for both sexes, this process can be made more difficult for males because of the masculine norms and values that dominate Western patriarchal societies. For example, that men should be seen as dominant and powerful, whereas survivors of sexual abuse are often seen as victims, which can sometimes be equated to being weak and powerless (Alaggia, 2010; Gagnier & Collin-Vézina, 2016).

Some studies have found that even when men do seek medical help after an assault they rarely disclose the sexual aspect of it and subsequently do not report the incident to the police (Isely, & Gehrenbeck-Shim, 1997; Walker, Archer, & Davies, 2005).

Interestingly, a study by Masho and Alvanzo (2010) found that only 17.6% of male victims sought professional help. Treatment services are often designed primarily to meet the needs of female survivors (Donnelly & Kenyon, 1996; Hooper & Warwick, 2006), and there have been calls for health services to consider the effectiveness of how they address men's needs and problems (Lab, Feigenbaum, & De Silva, 2000).

1.2.5 Rationale and Aims for Systematic Review

The amount of research on male survivors of SA is relatively small, and the evidence is especially limited in terms of male disclosure following sexual abuse (Young et al., 2016). What research has shown is that the consequences of SA in males are significant, and that a better understanding of the barriers regarding men's disclosure and help-seeking for SA is needed.

For the purpose of the present review the term "barrier" has been defined as "any factor that decreases the likelihood that a survivor will tell someone

else about his ... victimisation or seek formal services for help in the aftermath of the victimisation” (Allen, Ridgeway & Swan, 2015, p. 104).

In order to improve services for male survivors and to help facilitate disclosure and help-seeking in this marginalised group, it is important to understand what exactly the barriers are that impede male survivors in seeking help. Thus, the aim of the present study is to systematically review the literature in the area of disclosure and help-seeking in male survivors of sexual abuse in order to answer the main research question, which is:

1. What are the barriers to disclosure and help-seeking in men who have been sexually abused?

It is hoped that by answering the above question that the present review will be able to identify salient implications for clinical practice, that are informed by the current evidence base. It is also hoped that the present literature review will identify promising avenues for future research in this area.

1.3 Method

1.3.1 Ethics

Before the review was conducted, ethical approval was sought and granted from the Coventry University Ethics Board. Project ID number: P50278. See appendix B for ethics certificate.

1.3.2 Systematic Literature Search

A systematic search of the literature for studies which investigated the experiences of men who have been survivors of SA and also examined their experiences or views of disclosure or help-seeking was carried out between November 2016 and January 2017. The most relevant databases covering literature within psychology, social criminology, and nursing were searched, which included: Applied Social Sciences Index and Abstracts (ASSIA), Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medline, PsychInfo and Web of Science. The reference lists of the final extracted articles were examined by hand for additional relevant articles.

Table 1: Search terms

Main Concepts	Synonyms	Location
Males	Boy*	Title
	Male ⁽¹⁾	Abstract
	Men	
Sexual Abuse	Child sex abuse ⁽¹⁾	Title
	Incest	Abstract
	Rape	
	Sex*	
	Sexual abuse ⁽¹⁾	
	Sexual offences ⁽¹⁾	
Help-Seeking	Disclos*	Title
	Help seeking	Abstract
	Help seeking behaviour ⁽¹⁾	

⁽¹⁾ These search terms were terms found in certain databases which were 'expanded' to include relevant sub-categories.

Table 1 presents an overview of the key search terms used in the databases. These terms included the main concepts and their synonyms, which were males (boy*, male, and men); sexual abuse (child sex abuse, incest, rape, sex*, sexual abuse, and sexual offences); and help-seeking (disclos*, help seeking, and help-seeking behaviour). All of these terms were searched for within the titles and abstracts. An initial search revealed that the additional term "barrier" was too narrow and omitted useful literature. Therefore only the broader terms of "disclosure" and "help-seeking" were used.

The Boolean search strategy for each of the five databases was:

PsychInfo: sexual abuse (expanded) OR sex offences (expanded) OR incest OR rape OR sex* AND human male (expanded) OR men OR boy* OR male AND help seeking behaviour (expanded) OR disclos*.

Medline: sex offences (expanded) OR sex abuse OR incest OR rape OR sex* AND male OR men OR boy* AND help seeking OR disclos*.

CINAHL: sex abuse OR sexual abuse (expanded) OR sex assault OR child abuse (expanded) OR incest OR rape OR sex* AND males OR men OR boy* AND help seeking OR disclos* OR help seeking behaviour (expanded).

ASSIA: child sex abuse (expanded) OR sexual assault OR incest OR rape or sex abuse OR sex* AND men (expanded) OR boy* OR male and help seeking (expanded) OR disclos*.

Web of Science: sex abuse OR sexual assault OR sex offence OR rape OR incest OR sex* AND men OR male OR boy* AND help seeking OR disclos* OR abuse reporting (expanded).

Where the option was available the population was set as male, the language was set to English and non peer reviewed studies were filtered out.

A general initial screening of the article titles and abstracts was conducted to exclude any articles that may not have been identified through the search filters that were not written in English or were not peer reviewed. During this

process articles which did not appear to focus on the topic of this review of sexual abuse and help-seeking in male survivors of SA were also screened out.

1.3.3 Inclusion/Exclusion Criteria

Table 2: Inclusion and exclusion criteria

Criteria	Include	Exclude
Gender	Male only studies Mixed sex studies that separate the data for males and females	Female only studies Mixed sex studies that do not separate the data for males and females
Age when abuse took place	All ages	N/A
Type of participant	Survivors of sexual abuse	Non-survivors / general population
Geography	Western countries	Non-Western countries
Disclosure data	Study findings discussing barriers of disclosure and help-seeking	Studies that failed to consider the barriers and only report disclosure rates Studies that examined police interview techniques and disclosure during this process
Type of sexual abuse	All forms of non-consensual sexual contact, or sexual contact before the age of 18 in which the perpetrator was at least 5 years older	Studies that combined the data of sexual abuse with other forms of abuse e.g. intimate partner violence, for purpose of analysis
Perpetrator	All kinds	N/A
Language of paper	English	Non-English

Table 2 highlights the inclusion and exclusion criteria used in the present systematic review. Studies were included if the participants were male, or if both genders were included in the study but the results were reported separately by gender. Due to the limited number of studies into the area of

male SA, it was decided not to impose an age limit in terms of when the sexual abuse took place, as SA can happen at any point in a man's life, however, the reasons for not disclosing this abuse may be similar across the lifespan (Masho & Alvanzo, 2010). Studies were included if at least some of the participants were survivors of SA. As the number of studies in the area is limited, studies conducted in Western countries were included, provided that the full text article was accessible in English. Studies that included some discussion of the barriers of disclosure or help-seeking were included. The present review also considered articles that included any form of SA such as incest and rape. A preliminary review of the literature indicated that most studies did not select participants based on who perpetrated the sexual abuse (e.g. family member, partner, stranger etc.). Therefore the present review considered abuse from all types of perpetrators.

Articles were excluded if they only examined participants' perceptions from the general population (i.e. non-specified survivors), or from professional groups (e.g. police or psychologists). In terms of geography, studies which were conducted in non-Western countries were excluded on the grounds that notions of male gender role, masculinity and homosexuality may differ greatly from Western countries (e.g. the disclosure of being sexually abused by a male perpetrator may be confounded with extra barriers such as the illegality of homosexuality). Those articles which only reported disclosure rates but did not examine the reasons behind them were also

excluded. Studies that focused on children's disclosure in a professional setting, such as during police interviews where abuse has already been suspected were excluded as the present review aimed to look at first hand disclosure of men within the general population.

1.3.4 Classification of Studies

References from all five database searches were collated using EndNote Online, a reference management software package. The process in which the studies were selected followed the Preferred Reporting Items for Systematic Reviews and Meta-Analyses (PRISMA) guidelines (Moher, Liberati, Tetzlaff, Altman, & The PRISMA Group, 2009). This selection process is demonstrated in Figure 1.

During the identification phase 1,316 articles were identified through database searches. 131 duplicates were removed and the remaining 1,185 records' titles and abstracts were screened. This resulted in 1,045 records being excluded as they were not relevant to the aims of the present review. The full texts of the remaining 140 articles were reviewed against the inclusion and exclusion criteria and a further 122 articles were excluded because they were not relevant to the review aims or did not meet its inclusion criteria. This resulted in 18 relevant studies which satisfied the review's inclusion criteria. Manual searches of the reference list of the 18 studies identified 2 further papers which also met the inclusion and

exclusion criteria. Therefore a total of 20 studies were retained for quality assessment considerations within the systematic review.

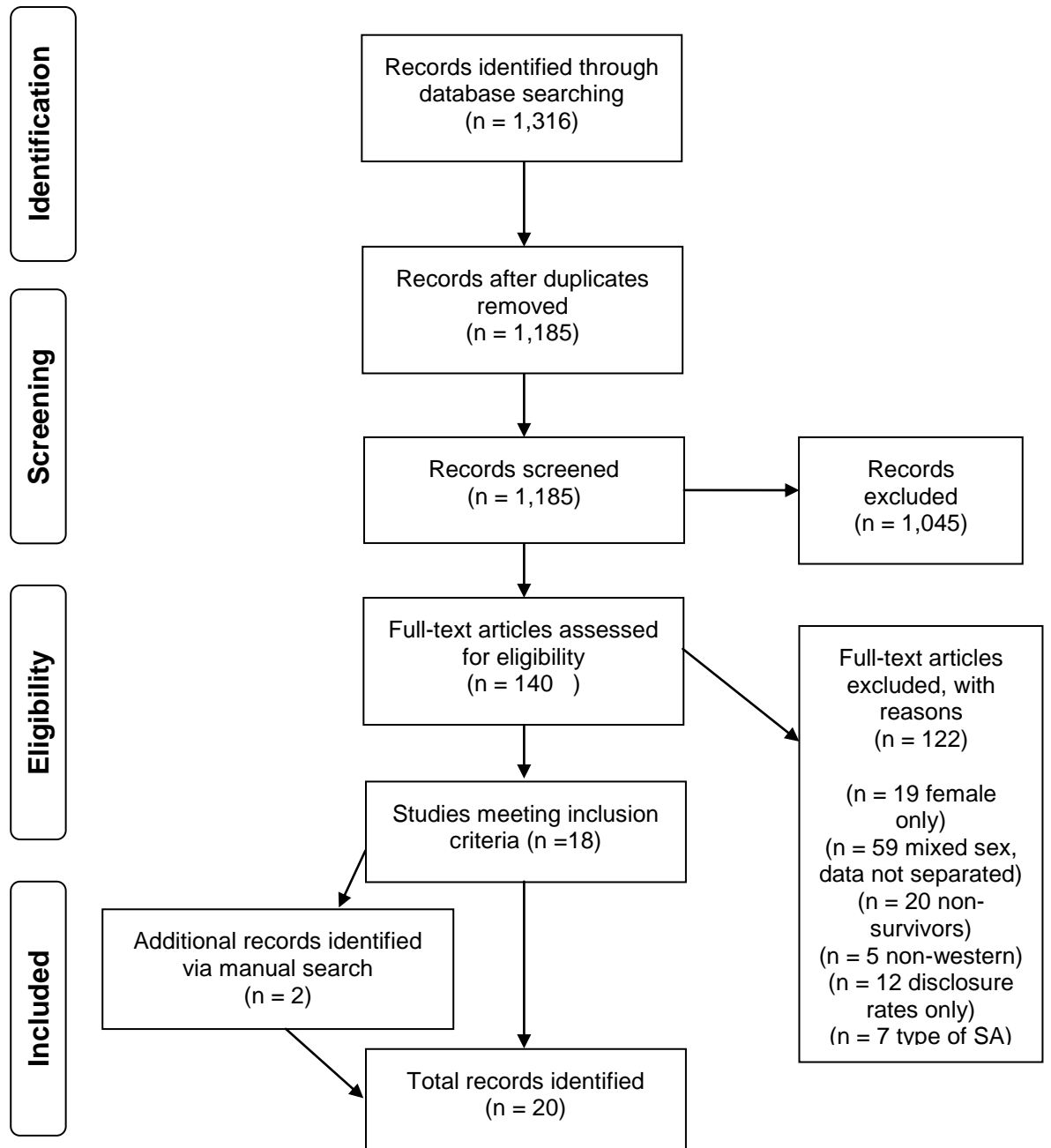


Figure 1: Adapted PRISMA flow diagram illustrating the selection procedure (Moher et al., 2009).

1.3.5 Quality Assessment

The final 20 papers were then assessed for quality using the quality assessment framework developed by Caldwell, Henshaw and Taylor (2005). This framework was considered suitable for the current review because it can be used with both quantitative and qualitative papers. The full list of questions can be found in appendix C. The checklist rates each section of the paper against a range of quality indicators over 18 questions. For each question a score of 0 (not met), 1 (partially met), and 2 (fully met) can be awarded, meaning that the highest score that be achieved is 36. Scores were then converted into a percentage, with a higher score indicating a higher quality.

No arbitrary cut-off score was used to exclude studies. Instead, the quality rating assessment scores were considered qualitatively to establish the overall quality of each paper, as well as the paper's unique contribution to the literature. However, if a paper scored under 50% then its shortcomings would have been considered in relation to what its data added to the review. For example, if a paper scored a quality rating of 40% but was the only paper to discuss the experiences of men in the military who had been sexually abused then this still may have been included in the review, with an acknowledgement to its lower quality level.

1.3.5.1 Inter-rater Reliability

To enhance the reliability of the quality assessment, five papers were also selected at random to be rated independently by another researcher, using the same quality assessment criterion. A Cohen's Kappa (k) test was used to statistically compare one researcher's rating with the other to give a Kappa coefficient score for each of the 5 papers. These scores are reported in Table 3, and there was an overall coefficient reliability value of $k=0.810$ which, represents a very strong pattern of inter-rater reliability (Altman, 1999).

Over the full 20 studies the quality rating ranged from 58% to 100%, indicating acceptable quality levels across the 20 studies. Consequently no studies were excluded through the quality assessment process.

1.3.6 Characteristics of the Literature

A summary of the key characteristics of the 20 studies included in this systematic review are provided in Table 3. The studies included were conducted in following countries: Australia (1), Canada (3), Chile (1), Mexico (1), New Zealand (1), South Korea (1), Sweden (1), UK (2), and USA (9). They were published between the years 1997 and 2016. The studies used a mixture of qualitative (e.g. IPA, grounded theory, and thematic analysis) and quantitative (e.g. surveys) methodology. Participants were males from a variety of different groups, including community

samples, people with mental health problems, survivors of clergy abuse and men in the military.

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Alaggia (2005)	1. To qualitatively explore dynamics that impede or promote disclosure by examining a range of factors including gender as a dynamic.	11 male survivors (19 female survivors)	Qualitative	Two themes emerged for men that were barriers to disclosure:	31/36 (86%)
Canada		Aged between 18-65	Interviews	1. Fear of being viewed as homosexual 2. Feelings of profound stigmatisation or isolation because of the belief that boys are rarely victimised	$k=0.670$
		Purposive sampling through community agencies, two university campuses and word of mouth	Interviews were transcribed and detailed coding resulted in the development of numerous categories and subcategories.	One theme emerged for men which acted as a precipitant for disclosure: 1. Fear of being an abuser	
Artime, McCallum, & Peterson (2014)	1. To describe the frequency of CSA and rape acknowledgment in a community sample of men that have experienced sexual victimisation 2. To examine the correlates of acknowledgment of CSA and rape 3. To compare men with no victimisation history, acknowledged	323 men	Quantitative	- 37% of sample endorsed behavioural indicators of CSA and/or adult rape - 52% of those that endorsed behavioural indicators of CSA did not self-label as CSA victims - 76% of those that endorsed behavioural indicators of adult rape did not acknowledge the experience as rape	32/36 (89%)
USA (91%)		Aged between 18-68 91% USA 1% Canada 3% UK 3% Other .01% Missing data Adverts placed online giving info and a link to the survey, which was completed anonymously	Survey administered online Descriptive statistics reported, chi-square analysis for correlates of acknowledgment, and ANOVA for acknowledgment and psychological distress.	- No differences in acknowledgement rates were found in survivors of CSA based on their relationship to the perpetrator ie family vs non family ($\chi^2 (2, 98) = 1.46, p = .48$) - Participants whose perpetrators used force were more likely to label the experience as sexual abuse, in both CSA: 76% vs 38% ($\chi^2 (1, 96) = 10.68, p = <.001$) and adult rape: 42% vs 8% ($\chi^2 (1, 44) = 7.15, p = .01$). - No differences in rates of CSA ($\chi^2 (1, 99) = 1.27, p =$	

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
	victims and unacknowledged victims on current levels of general psychological distress 4. To examine whether CSA acknowledgment is associated with sexual re- victimisation			.26) or adult rape (χ^2 (1, 44) = .40, p = .53) acknowledgment were found based on sexual orientation Acknowledgement rate based on gender of perpetrator: 5% female compared to 56% male (χ^2 (1, 30) = 10.16, p = .01), compared to 43% male and female (χ^2 (1, 28) = 6.22, p = .04) Perpetrators: - 49% female only 20% male only 16% both male and female - 16% stated that had not experienced any type of victimisation which was inconsistent with their previous responses - Men who acknowledged CSA endorsed significantly greater psychological distress than non-victims (M = 48.00; SD = 34.16, p = < .001). - Those who labelled their experience of CSA as sexual abuse were more likely to have been raped as an adult (42%) vs. men who did not acknowledge CSA (11%), (χ^2 (1, 99) = 11.94, p = < .001)	
Dorahy & Clearwater (2012) New Zealand	1. To understand further the lived experience of adult males who have experienced CSA. In particular the	7 men with experience of CSA Aged between 37-64 Participants recruited	Qualitative A focus group lasting 90 minutes conducted and	4 super-ordinate themes emerged with 3 subordinate themes, which were: 1. Self-as-shame - Foundations of self-as-shame - Fear of exposure	32/36 (89%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
		study online		- Past Responses	
Frías, & Erviti (2014)	1. To analyse the prevalence and factors associated with experiences of SA among Mexican adolescents	14,303 students completed the survey (45.3% were male). 13,440 cases used in the analysis as some surveys were incomplete	Quantitative Survey Descriptive stats	Personal: - Internal emotions - Naming the experience - Sexual orientation 5.07% of males reported being sexually abused (7.93% of females). Males were more likely to be abused by teachers, aunts or uncles, and mothers or step-mothers, than females.	32/36 (89%)
Mexico	2. To identify the perpetrators of SA 3. To examine whether or not the abuse was disclosed, whether charges were pressed, and to identify the sex of the adolescent involved	Data collected from surveys completed by adolescents attending the Ministry of Public Education high schools during the 2007-2008 school year.		30.97% of males had spoken to someone about the abuse (43.82% of females had done so) More males than females preferred not to disclose the abuse because: - It was something very personal (27.88% vs. 14.47%) - There was no reason to tell anyone about it (28.76% vs. 8.49%) - Participants reported loving the person who abused them (11.06% vs. 3.14%).	
Gagnier & Collin-Vézina (2016)	1. What are the experiences of male CSA survivors when disclosing	17 male survivors of CSA Aged between 19-67	Qualitative Data came from part of a larger	Main themes and sub-themes: Disclosure trajectory: - Disclosing for the first time - Waiting to tell	36/36 (100%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Canada	their abuse? 2. How do these experiences differ or resemble one another?	(average 47) 6 chose to be interviewed in English, 11 chose French Participants recruited through community and mental health organisations that offered support to survivors of sexual abuse in 4 large Canadian cities	study. Transcripts from telephone interviews Phenomenological method and interpretive description used to analyse the data	- Stereotypes contributing to delayed disclosure - Trying to forget - Breaking the isolation as a motivator to disclosure - Impact of various forms of media on disclosure Disclosure Experiences - Positive disclosure experiences - Negative disclosure experiences - Desire to protect others - Support in a non therapeutic context - Experiences of non disclosure - Disclosing with ease	
Hunter (2011)	1. How and when do people decide to tell others about their early sexual experiences with adults?	9 men, 13 women Aged between 25-70.	Qualitative Narrative inquiry	Themes particularly relevant to males: Shame: - About hidden homosexuality - Of becoming homosexual - Of being labelled as homosexual	27/36 (75%)
Australia		Participants recruited via press releases and interviews on local radio.			
Isely, Isely, Freiburger, & McMackin (2008)	1. To explore the immediate and long term impact of sexual abuse on men abused by the clergy, and to give	9 male survivors of SA by members of the Catholic clergy. Aged between 31-67.	Qualitative Interviews Theme analysis	Pertinent findings for current review: - Most feared they were somehow attracting men and questioned their sexual identity - Shame & guilt, and not wanting others to find out - Severe betrayal of trust by someone deemed as trustworthy	21/36 (58%) k=0.831

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
USA	a voice to a small representative sample of survivors.	Participants recruited in coordination with the Survivors Network of those Abused by Priests (SNAP)		- Thinking others would not believe them - Participants did not initially identify their experiences as sexually abusive	
King & Woollett (1997)	1. To determine the nature of sexual assaults experienced by men consulting a counselling service for male survivors of SA, and their help-seeking behaviour following the assault.	115 male survivors of SA Aged between 17-51 (mean=31.6) Anonymised data collected from the counselling service 'Survivors' between Jan 1993 and Dec 1994 of men who had attended face to face counselling for SA.	Quantitative Survey style data collection, included demographic information, details of the assault and help- seeking behaviour. Bivariate comparisons using t-tests and chi-square. Multivariate logistic regression	Mean time between the assault taking place and reporting it to Survivors was 16.4 years. This was 7.3 years for men who had been assaulted aged 16 or over. - 77% had sought no help after the assault. - 15% reported the assault to police. - 8 people found the police helped, 5 had a negative experience. - 27% had previously received counselling for the assault. Reasons for not reporting: - 6 were too ashamed - 2 were trying to forget - 2 were too frightened - 1 could not talk about it - 1 saw no point in reporting For victims assaulted under age 16, the assault was more likely (Odds Ratio = 9.2, <i>CI</i> = 1.5-56.7, <i>df</i> = 1, <i>p</i> =.02) to be their first sexual experience, and they were more likely to delay contact with 'Survivors' for more than 17 years (Odds Ratio = 19.4, <i>CI</i> = 2.1-182.3, <i>df</i> = 1, <i>p</i> = .009).	24/36 (67%)
UK					

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Kwon, Lee, Kim & Kim (2007) South Korea	1. To investigate the frequencies, causes and circumstances surrounding sexual violence and look for characteristic features of sexual violence among men in the military in South Korea	671 South Korean men surveyed that had either left the military within the past 3 years or were still serving	Quantitative Surveys on two groups: Those that had left the army within the past 3 years Active members	They were also less likely to report to police (Odds Ratio = 0.19, <i>CI</i> = 0.01-1.0, <i>df</i> = 1, <i>p</i> = .05). Victims assaulted by more than one person were more likely to be assaulted by strangers (Odds Ratio = 11.0, <i>CI</i> = 1.2-99.7, <i>df</i> = 1, <i>p</i> = .03), by women (Odds Ratio = 9.0, <i>CI</i> = 1.9-43.6, <i>df</i> = 1, <i>p</i> = .006), and to have suffered physical harm (Odds Ratio = 4.1, <i>CI</i> = 1.1-14.9, <i>df</i> = 1, <i>p</i> = .04). They were less likely to have experienced the assault as their first sexual experience (Odds Ratio = 0.17, <i>CI</i> = 0.04-0.75, <i>df</i> = 1, <i>p</i> = .02). - 15.4% had been directly victimised - 7.2% had direct experience as perpetrators - 24.7% had witnessed sexual violence in the military	23/36 (64%)
		8 perpetrators in the army prison were interviewed 3 victims were interviewed 6 sets of treatment notes of male victims who sought help were also reviewed	Interviews with perpetrators and victims	Themes: - Sexual violence is trivialised as intimacy - Sexual violence as a tool for controlling the male body - Coercive and intentional sexual violence accompanied by physical violence - Sexual violence in public - Accepting the abuse as part of everyday military culture Fear of being labelled as gay	

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Lab & Moore (2005) UK	1. To investigate the extent and characteristics of CSA in a sample of men attending psychiatric services 2. To retest the hypothesis that men do not label underage sexual experiences with adults as “sexual abuse”	<p>Researchers met soldiers on leave at train and bus stations and visited the Korean army</p> <p>74 male psychiatric inpatients</p> <p>English speaking</p> <p>Not deemed too emotionally distressed to participate</p> <p>White 43% Black Afro-Caribbean 41% Black African 12% Other ethnic groups 4%</p> <p>Experienced sexual contact aged 13 or under with someone 5 years or more older, or a family member at least 2 years older</p>	<p>Quantitative</p> <p>Questionnaire</p> <p>Descriptive stats</p>	<p>- 31% had experienced CSA</p> <p>- 35% did not describe their experience as SA</p> <p>- 52% had never disclosed the sexual abuse to anyone</p> <p>- 22% had the abuse mentioned in their medical records</p>	30/36 (83%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Lehrer, Lehrer, & Koss (2013)	1. To examine the prevalence of and risk factors for unwanted sexual experiences since age 14	Staff from 5 wards in a south London psychiatric hospital asked to identify potentially suitable patients from their wards, who were then approached for their consent to participate 416 male university students Spanish speaking Aged between 17-30 (median 20)	Quantitative Questionnaire Descriptive stats	- 9.4% reported USE before age 14 - 20.4% reported some form of USE since age 14 - 68% of perpetrators were female Disclosure rates: - 74.3% someone - 65.7% friend - 2.9% psychologist or social worker - 0% police Reasons for not disclosing: - 50% did not think it was serious enough or a crime - 14.3% I wasn't sure the person who did this really wanted to hurt me - 14.3% I felt ashamed - 9.5% fear of revenge - 7.1% if I told the police they would not respond	32/36 (89%)
Chile	2. To examine the contexts and reasons for non-disclosure of unwanted sexual experiences	Students were asked to complete the questionnaire during 25 minutes allocated at the start of class			
Masho & Alvanzo	1. To examine the help-seeking	705 men	Quantitative	- 91 participants had been sexually assaulted. - 17.6% had received professional help.	29/36 (81%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
(2010) USA	behaviours of men who have been sexually abused or assaulted in a community-based sample.	Older than 17 Sexual assault victims (n=91): 72.4% white 27.6% other Population based cross sectional study, using an independent, equal-probability sample drawn to represent the population of Virginia.	Telephone survey, using random-digit-dialling method. Logistic regression was used to analyse the data	Significant predictors of help-seeking were: - Physical injury ($OR = 10.91$, 95% $CI = 1.99-21.25$) - Perpetration by family or friend ($OR = 6.16$, 95% $CI = 1.45-29.9$)- Threat at the time of the incident ($OR = 7.56$, 95% $CI = 2.13-26.57$)	
Monk-Turner & Light (2010) USA	1. To understand better what key factors shaped the likelihood of ever seeking counselling among adult men who had experienced SA.	219 males who were survivors of SA. 79% White 9% African American Data drawn from the 1994-1996 Violence and Threats of Violence Against Women and Men in the United States Survey. Men who ever reported being a	Quantitative Data were collected through telephone interviews. Logistic regression analysis was used to analyse the data.	- 88% did not report the assault to police. - Only one variable was significantly related to help-seeking. Results showed that men who reported that penetration had occurred during the assault were 58% less likely to see counselling ($b = -.85$, $e^b = .42$, $SE = .35$, $p \leq .01$) - All other variables were non-significant: -- Using drugs ($b = -.13$, $e^b = 0.88$, $SE = 0.46$) -- Weapon used ($b = 1.99$, $e^b = 7.31$, $SE = 1.09$) -- Threatened ($b = -.42$, $e^b = .65$, $SE = .43$) -- Reported injuries ($b = -.51$, $e^b = .60$, $SE = .67$) -- Sought medical care ($b = -1.20$, $e^b = .30$, $SE = 1.02$)	31/36 (86%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
		survivor of SA or rape were included.		-- White ($b = -.48$, $e^b = .62$, $SE = .45$) -- Reported to police ($b = -.25$, $e^b = .78$, $SE = .53$) (p values for these variables were not reported)	
Priebe & Svedin (2008)	1. To investigate disclosure patterns associated with recipients of disclosure, abuse characteristics, socio-demographic variables, perception of parents when growing up, and current perceived mental health, separate for boys and girls	2,015 boys (2,324 girls) All were third year students at secondary school from the capital city, a large port town, and three smaller cities in Sweden. Mean age was 18.15 years.	Quantitative Questionnaires with a total of 65 questions, taking 30-60 minutes to complete. Data analysed using univariate and multivariate analyses.	- 23% of boys and 65% of girls reported experience of SA. - The disclosure rate was 69% for boys and 81% for girls; however this was most often to a friend. - 45.5% of boys and 17.3% of girls did not answer the questions about disclosure. Boy non-completers were two times more likely to have one or both parents unemployed ($aOR = 2.18$, $CI = 1.49-3.19$) - 8.3% of the adolescents had talked to a professional about the abuse. - The more severe the abuse, the less likely boys and girls spoke to either parent or a sibling. More severe abuse was also associated with lower rates of disclosure to professionals for boys ($OR = .15$, $CI = .03-.71$), but higher rates for girls ($OR = 3.12$, $CI = 1.13-8.61$), - Non-disclosing boys were more often sexually abused by a family member or friend, were more often studying a vocational program and lived more often with both parents than boy disclosers Non-disclosing boys perceived their parents during childhood more often as less caring in combination with lower overprotection, than boy disclosers. - Adolescents who experienced SA reported significantly more mental health symptoms (girls: $M(SD)$: abused 15.38 (4.68), not abused 14.00 (4.68), $t(df) = -6.79$ (2298), $p \leq .001$; boys: $M(SD)$: abused 14.21 (4.71), not	31/36 (86%)
Sweden	2. To examine predictors of non- disclosure, separate for boys and girls	The director of each participating community was asked to give permission for the research. Students in selected classes then asked to give consent to take part.			

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Sorsoli, Kia- Keating, & Grossman (2008)	With regards to male survivors of CSA:	16 men who were survivors of CSA	2 in depth semi- structured interviews, lasting between 2-3 hours each, taking place approximately a week apart.	abused 12.65 (4.37), $t(df) = -6.31 (703.20), p \leq .001$, and in general non-disclosers reported more symptoms than disclosers (girls: $M(SD)$: discloser 15.27 (4.71), non- discloser 16.26 (4.7), $t(df) = -2.89 (1232), p = .004$; boys: $M(SD)$: discloser 13.97 (4.55), non-discloser 15.53 (4.80), $t(df) = -2.45 (246), p = .015$).	34/36 (94%)
USA	1. To whom and in what contexts have they disclosed these experiences? 2. What do they have to say about these disclosure events? 3. What are their perceptions of the positive and negative aspects of their disclosure experiences, including both incentives and barriers to disclosure?	11 Caucasian 2 African American 1 Puerto Rican 1 part Native American 1 African Cuban Aged between 24-61. 9 heterosexual 5 gay 2 bisexual Participants recruited from men who responded to flyers posted a numerous institutions in the community.	Data were analysed using a grounded theory approach to coding and the use of conceptually clustered matrices.	Three major themes and sub-themes emerged from the data: Personal: - Cognitive awareness - Intentional avoidance - Difficulty approaching topic - Difficulty with articulation - Emotional readiness - Shame - Emotional safety Relational: - Fear of specific negative repercussions - General relational disruptions - Isolation - Relational beliefs Socio-cultural: - Unacceptability	$k=0.727$

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Teram, Stalker, Hovey, Schachter, & Lasiuk (2006) Canada	1. To inform an understanding of male survivors' experiences, particularly in relation to their encounters with health professionals	A brief telephone screening was then conducted.			27/36 (75%)
		49 male survivors 46 female survivors 18 years or older English speaking All experienced CSA Self-selected through responding to adverts placed in health agencies offering support to survivors of sexual abuse	Qualitative Interviews and focus groups Method of analysis not explicitly specified	Themes and sub-themes identified: Lack of concern regarding sexual abuse of boys by women - Male survivors abused by women are considered to be 'lucky' - Perpetrators often only seen as male Homophobia - Assumed to be gay - Struggled with own sexual identity - Their own homophobia of other men - The image of male survivors as potential perpetrators Manhood and the vulnerability for victims - Men don't cry - Men's difficulty acknowledging and expressing feelings Malecentric communication - Services clearly acknowledging the experiences of men	
Turchik, McLean, Rafie, Hoyt, Rosen, & Kimerling (2013)	1. To gain a better understanding of the perceived barriers to accessing military sexual trauma related care for	20 male veterans who had experienced military sexual trauma but had not accessed mental health care Sample recruited via	Qualitative Semi-structured interviews lasting approx. 45 min Analysed using	Themes and sub-themes identified: - Stigma-related barriers - Not wanting to talk about problems - Embarrassment/shame - Privacy/Confidentiality - Self-blame - Not important or serious enough	33/36 (92%)

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
USA	male veterans	Veterans Health Administration, who had screened positive for MST, but had not received any MST related mental health care.	grounded theory	<ul style="list-style-type: none"> - Sensitivity and reactions of a provider - Fear that they won't be believed 	
	2. To explore men's preferences concerning the gender of health care providers	99 men with an address 25 miles from interview centre selected and mailed until a target of 20 participants was reached		Gender-related barriers <ul style="list-style-type: none"> - Men less affected than women - Masculinity - Provider gender preferences Knowledge Barriers <ul style="list-style-type: none"> - Lack of knowledge about service availability - Financial concerns regarding services 	
Weiss (2010)	1. To explore and deconstruct the shame of sexual victimisation by highlighting the ways in which shame is socially constructed and culturally mediated	20 male victims (116 female victims)	Qualitative	Themes and sub-themes identified:	31/36
USA			Survey	Men's shame narratives:	(86%)
		Males: 74% under 25 year old 38% white 25% black 38% other races Data were extracted from sexual victimisation narratives collected	Open ended question narrative analysed using grounded theory approach.	<ul style="list-style-type: none"> - The disempowered victim - The emasculated victim - The exposed victim 	k=0.852

Table 3: Summary of study characteristics

Author(s) Date Country	Aims and topics covered	Sample characteristics & Recruitment Strategy	Data collection and analysis	Key findings	Quality Rating & Kappa
Young, Pruett, & Colvin (2016)	1. To compare the documented call narratives of male sexual assault survivors with female sexual assault survivors who called a telephone hotline, with the intent to understand better the help-seeking behaviour and experiences of male sexual assault survivors.	<p>by the National Crime victimisation survey in the USA from an open ended question Shame narratives were then identified and included in the study.</p> <p>58 male SA survivors (58 female SA survivors)</p> <p>Aged between 15-61</p> <p>Data came from documentation of hotline calls from a sexual assault centre from callers who called between 2008-2012.</p> <p>58 male survivors were identified and 58 females were randomly selected for comparison.</p>	<p>Mixed methods approach.</p> <p>Quantitative variables: duration of call, sex of victim, age, date of assault, severity of call, urgent/non-urgent, what was provided to each caller (e.g. information, empathy & referral)</p> <p>Summative content analysis</p>	<p>- No significant differences between males and females based on severity of calls (stats not reported)</p> <p>Themes identified for male callers:</p> <ul style="list-style-type: none"> - Hotline used due to limited or no support - Used to access counselling only - Distrust of others - Confusion around boundaries 	32/36 (89%)

1.4 Results

A configurative approach (Gough, Thomas & Oliver, 2012) to data synthesis was used to identify the main barriers to disclosure for male survivors of SA. This approach focuses on identifying salient themes across the studies reviewed. Five emergent themes were identified: unwillingness to acknowledge the SA; the nature of the abuse and abuser factors; perceptions of sexual orientation; stigma and shame; and mistrust of others and services.

1.4.1 Unwillingness to Acknowledge the SA

This barrier was referred to in thirteen of the papers included in this review (Arttime et al., 2014; Dorahy & Clearwater, 2012; Easton et al., 2014; Frías & Erviti, 2014; Gagnier & Collin-Vézina, 2016; Isely et al., 2008; King & Woollett, 1997; Kwon et al., 2007; Lab et al., 2000; Lehrer et al., 2013; Sorsoli et al., 2008; Turchik et al., 2013; Weiss, 2010). Male survivors tended to be unwilling to acknowledge the abuse and dismiss it, or acknowledge something happened but then deny and repress it. For example, Arttime et al. (2014) found that 52% of their participants who had endorsed behavioural indicators of at least one experience of CSA did not label themselves as CSA victims. Among the participants that were raped as adults, 76% did not acknowledge this experience as rape. Some survivors may see the abuse as “just part of growing up” (Easton et al.,

2014, p. 466) or accepting it as part of the culture they are in, such as military culture (Kwon et al., 2007).

Five of these studies discussed that some male survivors of SA used denial or repression to try and actively forget about their experiences either consciously or unconsciously. This sometimes resulted in flashbacks and further psychological distress (Gagnier & Collin-Vézina, 2016). Some men in Easton et al.'s (2014) study commented that they used substances to further help block out distressing memories. Most male survivors in Dorahy and Clearwater's (2012) study also spoke about how they deny and repress their feelings as a way of coping with their experience, resulting in a numbness or disconnection.

1.4.2 The Nature of the Abuse and Abuser Factors

There were thirteen studies which discussed a range of factors relating to the nature of the abuse and the abuser (Arttime et al., 2014; Easton et al., 2014; Frías & Erviti, 2014; Gagnier & Collin-Vézina, 2016; Isely et al., 2008; King & Woollett, 1997; Kwon et al., 2007; Lehrer et al., 2013; Masho & Alvanzo, 2010; Monk-Turner & Light, 2010; Sorsoli et al., 2008; Teram et al., 2006; Weiss, 2010). A number of factors regarding the abuse itself have been found to be significant predictors of male survivors seeking help from a counsellor, sexual assault hotline or medical doctor. These include if

there was physical injury during the incident, if there was a threat at the time of the incident or if there was a perceived risk of being in danger (Masho & Alvanzo, 2010). The majority of men (76% vs. 38%) in Arttime et al.'s (2014) study were more likely to acknowledge their experience as CSA if physical force was used compared to when it was not. This rate was also a lot higher (42% vs. 8%) in men who experienced adult rape, acknowledging it as such if physical force was used.

This can become a barrier as some survivors stated feeling that there was no reason to disclose the abuse or that what had happened to them was not serious enough to disclose. In Lehrer et al.'s (2013) study, 50% of participants stated that they did not think what had happened to them was serious enough to report to the police. Similarly, 28.76% of the male survivors in Frías and Erviti's (2014) study felt there was no reason to tell anybody about their abuse.

However, similar results were not found by Monk-Turner and Light (2010) who looked at predictors of seeking counselling among male survivors of SA. They found no significant difference regarding whether if men were under the influence of drugs during the assault, threatened, had a weapon used against them, and whether or not an injury was reported. What they found significant was that the odds of seeking counselling decreased by

58% if the male survivors reported that penetration happened during the abuse.

In terms of the abuser, the status of the perpetrator was seen as a barrier for some male survivors who were abused by members of the clergy, and thought they would not be believed, were somehow 'bad' themselves or would go to hell if they told anyone (Easton et al., 2014; Isely et al., 2008). This highlights a sense of fear of the abuser by the survivors. Many survivors throughout the studies stated that they feared revenge or other negative repercussions from the perpetrator if they disclosed the abuse, so instead chose to remain silent (e.g. Easton et al., 2014; Lehrer et al., 2013).

Some of the men in the military that participated in Kwon et al.'s (2007) study said that they did not disclose the abuse because of their relationship with the perpetrator, who was most likely to be a higher ranking soldier. In the general population, males were also more likely to state a reason for non-disclosure was because they loved the person who abused them (Frías & Erviti, 2014).

When the perpetrator is female, there is an overlap with other themes identified in the present review, such as a feeling of shame and stigma (Gagnier & Collin-Vézina, 2016), and an unwillingness to acknowledge the SA as abuse, with only 5% of men doing so (Artine et al., 2014).

1.4.3 Perceptions of Sexual Orientation

There were four studies which identified male survivors doubting their own sexual orientation as a barrier to disclosing the abuse (Easton et al., 2014; Hunter, 2011; Isely et al., 2008; Teram et al., 2006). Some male survivors who experienced sexual abuse perpetrated by men were concerned they were selected by the perpetrator because they were gay (Hunter, 2011), or had been perceived as gay by the perpetrator even though they identify as heterosexual (Teram et al., 2006), and then feared the abuse was evidence they were actually gay (Easton et al., 2014; Isley et al., 2008).

Eight studies identified that some male survivors of SA have a fear of being viewed as gay, both by other people that they know as well as service providers (Alaggia, 2005; Easton et al., 2014; Hunter, 2011; Isely et al., 2008; Kwon et al., 2007; Teram et al., 2006; Turchik et al., 2013; Weiss, 2010). This belief falls in line with the myth that “only gay men are sexually assaulted” (Turchik et al., 2013, p. 219). A concern of some men that identified as heterosexual was that they would be assumed to be gay and that they deserved or wanted the abuse (Teram et al., 2006). This was a view also shared by men that identified as gay, who had the additional concern that people would believe the SA “made” them gay (Easton et al., 2014, p. 465).

Some men expressed a concern that they would be negatively judged or stigmatised by being perceived as gay (e.g. Hunter, 2011; Weiss, 2010), especially if they grew up in homophobic environments (Alaggia, 2005). Teram et al. (2006) found that some of their participants had homophobic views, which led them to suspect the sexual orientation of other men. This in turn had an impact on their engagement with male health professionals.

1.4.4 Stigma and Shame

Twelve studies identified stigma and shame as an important barrier to disclosure for male survivors of SA (Alaggia, 2005; Dorahy & Clearwater, 2012; Easton et al., 2014; Gagnier & Collin-Vézina, 2016; Hunter, 2011; Isely et al., 2008; King & Woollett, 1997; Lehrer et al., 2013; Sorsoli et al., 2008; Teram et al., 2006; Turchik et al., 2013; Weiss, 2010). Feelings of stigma and shame may occur when being a victim is at odds with men's narratives of what a 'real man' is, i.e. someone who is able to defend himself against victimisation, strong, masculine, and dominant (Alaggia, 2005; Weiss, 2010). Some men stated they felt there is a stigma surrounding men who talk about SA, and that it is a taboo to be recognised as a victim (Gagnier & Collin-Vézina, 2016; Teram et al., 2006). By surviving SA a man may feel he could have done more to stop the abuse occurring (Weiss, 2010). For example, if he had been less drunk he could have fended off the perpetrator; he may have felt shame from being forced into submission; and emasculated, especially by female perpetrators as it goes against the notion that women are incapable of rape, inverts

heterosexual norms and goes against the idea that a man should always be willing to have sex and lucky that he did (Teram et al., 2006).

In their study, Dorahy and Clearwater (2012) found that participants scored considerably higher on trait shame and guilt than rates reported for college and mixed psychiatric samples. Survivors spoke about shame as something which stopped them from telling others because they feared being 'found out'. Part of the reason suggested by the Dorahy and Clearwater (2012) is that there is an uncertainty about how others may react, which in turn can lead to avoidance.

There were participants who believed that because men are "tougher" than women, that they should be less emotionally affected by the abuse and therefore would be less likely to deserve or need treatment for it (Turchik et al., 2013, p. 218). These thoughts are consistent with the myth that "women are more affected by sexual assault" (Turchik et al., 2013). These feelings of stigmatisation also come from services. Some men felt there is little support for male victims, which perpetuates the myth that males do not get sexually abused (Alaggia, 2005).

1.4.5 Mistrust of Others and Services

Eight studies identified that mistrust, both of other people generally and of service providers, acted as a barrier to men disclosing their experience of SA (Dorahy & Clearwater, 2012; Easton et al., 2014; Isely et al., 2008; King & Woollett, 1997; Lehrer et al., 2013; Teram et al., 2006; Turchik et al., 2013; Young et al., 2016). Men in studies by both Easton et al. (2014) and Isely et al. (2008) said that their ability to trust others had been shattered by the abuse they experienced, especially if the abuse was perpetrated by someone who held a trusted and respected position in society such as a member of the clergy.

When comparing the help-seeking behaviour of male and female survivors of SA who accessed a sexual assault hotline, Young et al. (2016) found that among male callers, there was a strong distrust of others evident through their behaviour during the call, such as by hesitating, avoiding questions and hanging up abruptly, the latter of which occurred in 25.9% of calls made by men.

With regards to professionals, other male survivors have stated that some health professionals are sceptical about men who disclose experiencing abuse and tend to take their experiences less seriously compared with women (Dorahy & Clearwater, 2012; Teram et al., 2006). Other men commented on their predicted reactions of service providers, believing

some may intentionally avoid the topic if they tried to raise it, display negative reactions such as shock, disgust or confusion, or not believe them (Isely et al., 2008; Turchik et al., 2013). With regard to reporting SA to the police, 7.1% of Chilean males in Lehrer et al.'s (2013) study believed that if they told the police they would not respond. In a UK sample of male survivors who had reported the assault to the police 8 participants found them to be helpful and 5 perceived the police's reaction to be negative (King & Woollett, 1997).

Finally, it was apparent that some male survivors do not know where to access help from (Turchik et al., 2013; Young et al., 2016). Alternatively, they knew of services, but they were more catered towards the needs of women, while some services did not provide support to men at all (Easton et al., 2014).

1.5 Discussion

The present study set out to systematically review the literature, in order to identify what the main barriers to disclosure and help-seeking are for male survivors of SA. Five salient barriers to disclosure and help-seeking were identified in the review. It is important to note that these five barriers do not operate in isolation from each other and that men's decision to disclose incidents of SA is often shaped and defined by a complex set of experiences. What appeared to permeate all of these themes and sub-themes was how male gender norms and male rape myths work at silencing male survivors in many ways. The studies included in this review spanned five continents, with diverse participants in terms of age, ethnicity, sexual orientation, type of sexual abuse experienced, and the type of setting they were in (e.g. the military, general population etc.). Yet the themes identified in this review were found throughout these studies, suggesting that these gender-related barriers may affect male survivors throughout Western cultures. This highlights the importance of having gender-specific research or the reporting of data separately based on gender, as although the experiences of both men and women are important, there are many gender-related differences in disclosure and help-seeking behaviour between them. The themes identified in this review were grounded in data from a number of the studies, and come together to help form a complex picture of disclosure and help-seeking in male survivors of SA.

1.5.1 Implications of Findings for Disclosure and Help-Seeking

As stated above, all five barriers identified in the current review shared a close link to masculinity in the context of disclosure of abuse and help-seeking. Masculinity and what it means to be male can be difficult to define, because it involves a complex interaction between a man or boy's physical, psychological and emotional development, combined with their interactions with the current social and cultural norms and their ethnicity (Meth, 1990). Gender roles are social constructions, rather than biological. From birth, both boys and girls are socialised with regards to gender roles. For boys, this influences how they see themselves in terms of masculinity and sets expectations on how they should behave, what they wear, their work roles and activities such as sexual conduct (Conrad & Warwick-Booth, 2010). 'Hegemonic masculinity' is a term used to define the dominant form of masculinity acceptable within a patriarchal culture (Connell, 2005). Men who do not conform to hegemonic masculinity may find themselves discriminated against (Farrimond, 2011).

The dominant discourse around what constitutes as being male and masculine is that of being independent, powerful, physically strong and almost invincible (Newman, 1997). Anything that deviates from this masculinity script of how a man should think, feel and behave is viewed as "feminine and unacceptable" (Meth, 1990, p. 4). Therefore, identifying

oneself as a male survivor of SA can go against this representation of being a man and may lead one to question his own masculinity. This masculinity may also be questioned if one is perceived as being gay (theme 3), which can be viewed as being feminine and differing from the concept of hegemonic masculinity (Connell, 2005). In the moment of experiencing SA a man has lost his power and dominance. Men may face external pressure to project a masculine image to others, which may often conflict with their own inner needs as these may be considered more typically “feminine” (Goldberg, 1983). It is therefore understandable why, as identified in theme 1, some men may prefer to deny or not acknowledge the abuse took place, and why they would not want to disclose, as this could shatter the masculine image they are working hard to outwardly project. Unhealthy practices, such as not visiting a doctor are often seen as displays of masculinity, as by dismissing their health needs and taking risks men can then legitimise themselves as the ‘stronger’ sex (Courtenay, 2000). However, with male survivors of SA this often leads to increasing levels of shame and feelings of emasculation (Dorahy & Clearwater, 2012), as identified in theme 4, as well as many psychological effects (e.g. Romano & De Luca, 2001).

Avoiding behaviour associated with being feminine can lead to gender-role strain and conflict. Gender-role conflict (GRC) is defined as a psychological state whereby socialised gender roles have negative consequences for the person or others, and can be experienced intrapersonally or interpersonally

(O'Neil, 2013). Several studies have examined masculinity and gender role conflict in relation to attitudes toward help-seeking (as discussed by Addis & Mahalik, 2003). A number of mediation models have been developed by researchers to try and explain or predict which factors are most associated with intention to seek help for men. For example, Pederson and Vogel's (2007) model states that relations between GRC and willingness to seek counselling are partially mediated by the tendency to disclose distressing information, by self-stigma associated with seeking counselling and by attitudes towards seeking counselling.

1.5.2 Barriers to Disclosure and Help-Seeking and the Theory of Planned Behaviour

Building on this, perhaps the most widely used model in the literature of predicting intentions to perform a behaviour is the Theory of Planned Behaviour (TPB, Ajzen, 1991). The TPB has been used to predict a variety of behaviours from breakfast consumption in British and Australian adolescents (Mullan, Wong & Kothe, 2013), to seeking professional help for depression (Schomerus, Matschinger & Angermeyer, 2009). The theory states that the performing of a behaviour is directly mediated by one's intention to perform the behaviour, which in turn is influenced by one's attitudes toward the behaviour (how favourable or unfavourable they view it), their subjective norms (one's perceptions of the stigma or reward for engaging in the behaviour), and one's perceived behavioural control (one's perception of how difficult or easy it is to perform the behaviour). To date,

studies have only tested a partial model of the TPB for predicting psychological help-seeking in men. However, these studies have found that adding the variables of gender role conflict and masculinity can play a mediating role within it (Shepherd & Rickard, 2012; Smith, Tran & Thompson, 2008).

It is possible to see how disclosure and help-seeking in male survivors of SA could theoretically fit the TPB, at least partially. Perceived behavioural control was captured in the present review by some men who stated they did not know where to seek help from, or felt there are not services available that cater to the needs of male survivors (theme 5). The subjective norms component of the TPB was captured by the theme of stigma and shame surrounding being a male victim (theme 4), which was also linked to their willingness to acknowledge the abuse (theme 1). Finally, some attitudes toward seeking help for SA were expressed, for example, some men stating that seeking help is more for women. However, the present review found two further barriers which do not fit within the standard constructs of the TPB, and are more specific to male survivors of SA than help-seeking in general. These were regarding the nature of the abuse and abuser factors (theme 2), as well as perceptions around sexual orientation (theme 3). It is possible that both of these could be framed within the added masculinity/GRC constructs added by the above mediation models.

1.5.3 Clinical Implications

The findings of the review suggested mistrust of services is an important barrier to male survivors of SA engaging with professional support that could best address their needs. It is important to consider how services and the professionals working within them may have also internalised the social construction of masculinity, gender roles and male rape myths. When presented with clinical vignettes of an adult client, which incorporated a number of indicators that the client may have been sexually abused, clinical psychologists practicing in the UK were twice as likely to hypothetically attribute sexual abuse in female clients, compared to male clients (Holmes & Offen, 1996). This study, together with Donnelly and Kenyon's (1996) study with law enforcement officers and female crisis workers shows that these rape myths can cut across professional groups, with potentially unhelpful consequences for those men who do eventually decide to seek professional help. Another finding from Holmes and Offen's (1996) study was that clinical psychologists who had qualified more recently were more likely to hypothesize that the client of either gender may have experienced sexual abuse. The authors note that at the time, sexual abuse workshops had only recently been incorporated into clinical psychology training, suggesting that greater training and awareness raising can minimise the effects of these male rape myths.

There was a notable absence of findings in the studies reviewed here on potential facilitators of disclosure in male survivors of SA compared to

barriers. This was reflected on by Sorsoli et al. (2008) who stated that most of their results focus on the struggles of disclosure rather than the successes, as the participants in their study shared few positive experiences. Nevertheless, there were four studies that identified some facilitators to disclosure (Alaggia, 2005; Dorahy & Clearwater, 2012; Gagnier & Collin-Vézina, 2016; Teram et al., 2006). Knowing other survivors of SA can help men to feel less alone and in turn encourage disclosure (Gagnier & Collin-Vézina, 2016). Connecting with other people was also found to reduce shame and increase a sense of belonging; however, this can be short-lived (Dorahy & Clearwater, 2012). This may provide some evidence for the usefulness of support groups for male survivors being used as a clinical intervention.

Findings from the papers reviewed here suggest that one of the messages men learn when growing up is that men should not express their vulnerabilities and should be careful to express only what they feel safe (Meth, 1990). Other facilitators found by Gagnier and Collin-Vézina (2016) were the importance of men needing to feel safe and to be able to trust the person they were disclosing to, as well as the importance of being believed, listened to, emotionally respected, and treated in a compassionate manner. Having staff members that are able to be more “male aware” (White & Conrad, 2010, p.259), and acknowledge male survivors and their own assumptions regarding them, may help to facilitate safer and more trusting environments and better relationships. This has implications of highlighting

the need of training for mental health professionals and other professional groups, such as the police, on the subject of the sexual abuse of men and boys.

In Gagnier and Collin-Vézina's (2016) study, some men found disclosing easier once it had become part of their personal narratives and were used to telling their account of what happened to them. Two of the men in this study expressed wanting to share their experiences on a wider scale by writing an autobiography. While eight men in total spoke about being positively impacted by the media and reading the biographies of other survivors, or hearing other survivors speak out on television talk shows, which then encouraged them to disclose themselves (Gagnier & Collin-Vézina, 2016).

In terms of what services can do, a survivor and long term activist who participated in Teram et al.'s (2006) study spoke extensively about "malecentric communication" (p. 511) as a way of helping men to disclose experiences of SA and seek help. He argues that services should be more explicit in saying that they also support the needs of male survivors, by explicitly using terms such as 'men' in their promotional literature, such as in their service leaflets and websites. The idea is to try and help men to feel the service is a safe place to access by addressing their concerns explicitly and publicly acknowledge that SA happens to men and how difficult it can

be for them. Educational and consciousness-raising material is also discussed, with employing celebrities to talk about their experiences of SA given as one example of how this could work.

1.5.4 Limitations

Overall, the studies included in the present review scored well on the quality assessment checklist, suggesting that the studies reviewed were in general transparently reported. Those studies that did score lower tended to omit details regarding ethical considerations of their study, aspects of data collection, reporting of methodology or data analysis. For example, by not justifying why a particular methodology was used and its theoretical background, which may have helped the reader to gain a better understanding of the epistemological position the researcher took and how they view the data. Some studies used data that was collected as part of another study, and therefore some of the scope into fully exploring barriers to disclosure and help-seeking may have been lost.

Although the majority of the findings from the studies either agree with or complement each other, there were some divergent findings across studies. Firstly, studies such as Artime et al. (2014) and Masho and Alvanzo (2010) found that when physical force was used male survivors were more likely to acknowledge the sexual abuse and to seek help for it. However, these results were not found in Monk-Turner and Light's (2010) study. However,

the latter study only focused on seeking counselling, rather than seeking help or disclosing in general, which may account for why these results were not important.

Secondly, two of the studies included in the present review found that fear of becoming an abuser acted as a barrier to disclosure for some male survivors of SA (Easton et al., 2014; Teram et al., 2006), whereas Alaggia (2005) found this fear could be a precipitator of disclosure. However, it is acknowledged by Alaggia (2005) that this can initially start off as a barrier and later become a precipitant, although possible reasons for this are not made clear. This is an important factor nevertheless as it can affect how men interact with their own and other children and even affect their decision to have children or not (Price-Robertson, 2012).

A final limitation to the present review is that the studies included within it have little focus on the facilitators to disclosure. Although many of the men who participated in the reviewed studies stated they did not have completely positive experiences of disclosure and help-seeking, they had attempted it nevertheless. However, they were rarely asked what facilitated these disclosures or what could have been made them more likely to do so.

1.5.5 Suggestions for Future Research

Findings from the present review indicate that more research is required into facilitators of disclosure and help-seeking in male survivors of SA. Additionally, if some of the barriers that have been identified were addressed it is possible that disclosure and help-seeking may be easier facilitated. White and Conrad (2010) note that many men's healthcare initiatives come from individual practitioners recognising a need for men, rather than as a consequence of mainstream health providers setting up services for men. More research into these initiatives aimed at male survivors of SA and what helps the services access men and to be accessed, may help to shed more light onto the area and increase the visibility of male survivors, in both society and the literature, for example, by investigating whether "malecentric communication" is effective. More research into this area may help to show the importance of these specialist services and provisions to mainstream healthcare providers and commissioners.

Additionally, there is a need to evaluate the effectiveness of training provided to professionals with regards to increasing awareness of professionals' own preconceptions around male SA, as has been indicated in studies such as Holes and Offen (1996).

Disclosure is not just a one off event, but a life-long process (Gagnier & Collin-Vézina, 2016; Hunter, 2011). It would be helpful to have longitudinal

studies that follow male survivors of SA to further understanding on the patterns of the disclosure and help-seeking process across the life span, and the factors that are implicated in these processes.

A further possible avenue for future research would be to test the full theory of planned behaviour in terms of how much it can account for male survivors' intentions to seek support for their abuse, as well as incorporating masculinity as an important additional component.

1.6 Conclusion

The present review has brought together existing research in the small but growing area of the barriers to disclosure and help-seeking in male survivors of SA. The findings suggest that the social construction of masculinity, gender norms and male rape myths permeate all of the five themes identified, and more research is needed to enhance understanding of this process and how it relates to disclosure and help-seeking in male survivors. The current literature on facilitators of disclosure and help-seeking is limited and further research in this area is recommended. The present review highlights a number of clinical implications for practitioners and services to consider, such as how they reach out to male survivors, their own potential stereotypes of male survivors and the potential consequences of SA on men and boys. Further training for professionals could be helpful in improving perceptions of services.

1.7 References

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Chapter 2: Factors affecting psychological help-seeking in men, using the theory of planned behaviour

Prepared for submission to **The Journal of Men's Studies** (see Appendix D for author guidelines).

Chapter word count: 7,942 (excluding tables, figures and references)

2.1 Abstract

Aim: Prior research shows that men as a group seek psychological help at relatively low rates. The current study aimed to examine factors that affect psychological help-seeking in men, using the theory of planned behaviour as a guide.

Method: A within groups quasi-experimental survey design was employed. Participants (n=236) were men aged 18-65 living in the UK. They were recruited online via social media and completed an online survey. Attitudes toward seeking professional psychological help, stigma, self-efficacy, and mental health literacy were measured using previously validated measures. Sources of seeking help and for which difficulties men were more likely to seek help for were also considered.

Results: Two components of the theory of planned behaviour, self-efficacy and attitudes, were found to be significant within the study. Men were most likely to endorse seeking help from their intimate partners and GPs and least likely from helplines and religious leaders.

Conclusion: Targeting mental health promotion in men's partners may encourage help-seeking from professional sources. More training in men's mental health for GPs would be advantageous, while the effectiveness of helplines for men as a group is questionable. More research is required into the factors of stigma and mental health literacy and their applicability to explaining psychological help-seeking intentions in men.

Keywords: theory of planned behaviour; help-seeking; men's health; mental health

2.2 Introduction

2.2.1 The Problem with Men's Mental and Physical Health

Suicide is the leading cause of death in England and Wales for men aged between 20 and 49 years old, with men in the 45 to 59 age group having the highest suicide rate out of any age group (Office for National Statistics [ONS], 2015a). Interestingly, the male suicide rate in the UK in 2013 was more than three times higher than the female rate (ONS, 2015a). With regards to mental health problems, men are nearly 50% more likely than women to be detained and treated compulsorily as psychiatric inpatients (Health & Social Care Information Centre [HSCIC], 2013), become alcohol dependent (HSCIC, 2015), and abuse substances (HSCIC, 2014). An average of 1.2% of men in work report stress, depression or anxiety caused or made worse by work within a 12 month period, with 45 to 54 year olds being significantly more likely to report this (Health & Safety Executive, 2016).

Globally, men have a relatively lower life expectancy (69.1 years) than women (73.8 years) (World Health Organisation, 2017). In the UK, men are more likely to die before women, with 40% of all men who died in 2012 being under the age of 75, compared to 26% for female deaths (ONS, 2013). Statistics also show that in each year between 2001 and 2013 in England and Wales the majority of potentially avoidable deaths were among males, with the most common cause being coronary heart disease

(ONS, 2015b). With cancer, more cancers in the UK during 2015 were registered in males than females (ONS, 2017). Men also make up the vast majority of people who sleep rough (Combined Homelessness & Information Network [CHAIN], 2014), and who are in prison (Ministry of Justice, 2015).

2.2.2 Help-Seeking in Men

From these statistics it is clear that men's physical and mental health can be problematic. Many deaths, could be avoided if men sought medical help sooner (ONS, 2015b). Similarly, with earlier intervention, psychiatric hospital admissions could also be reduced (Bird et al., 2010). However, men are less likely to seek help for both physical health (e.g. Wang, Hunt, Nazareth, Freemantle & Petersen, 2013) and psychological difficulties (e.g. Oliver, Pearson, Coe & Gunnell, 2005). The number of studies in the area of men's psychological help-seeking is small but growing. However, its importance is high. The high incidence of physical and mental health morbidity contrasts with underrepresentation in psychological services, suggesting that a greater understanding of the factors that influence men's psychological help-seeking is required.

A number of variables have been linked with help-seeking behaviour in men. Studies of physical health problems such as impotence and bowel problems have identified some of the barriers to seeking help as being

embarrassment, ignorance and misinterpretation of the symptoms (Ansong, Lewis, Jenkins & Bell, 1998; Oberoi, Jiwa, McManus & Hodder, 2015). Masculine ideology and masculine gender-role conflict (GRC) have also been linked to help-seeking in men (Addis & Mahalik, 2003). The former focuses on one's beliefs about what it means to be a man and one's degree of endorsement of cultural norms and values regarding masculinity. Whereas GRC focuses on the negative consequences for wellbeing in men adopting particular masculine ideologies e.g. that men should be tough. A number of studies have looked at the relationship between GRC and help-seeking (Good, Dell & Mintz, 1989; Levant, Wimer, Williams, Smalley & Noronha, 2009; Pederson & Vogel, 2007; Shepherd & Rickard, 2012; Vogel & Wester, 2014). These authors found a significant relationship between traditional male role attitudes and having a negative attitude toward help-seeking attitudes and behaviour. These studies also identify other variables linked to help-seeking such as attitudes and stigma, while a study by Sullivan, Camic and Brown (2015) found a link between masculinity, alexithymia and fear of intimacy. Research by Smith, Tran and Thompson (2008) attempted to provide a theoretical foundation using the Theory of Planned Behaviour (TPB, Ajzen, 1991) as a guide.

2.2.3 The Theory of Planned Behaviour

The TPB (see Figure 1 below) suggests that behaviour is most accurately determined by one's intentions to do the behaviour and that there are three variables which will predict one's intention (Ajzen, 1991). These are: attitudes towards the behaviour (beliefs about the consequences of a behaviour and one's own positive or negative judgements about the behaviour); subjective norms about the behaviour (one's own estimate of the social pressure to perform or not perform the behaviour and the positive or negative judgements and stigma about each belief); and perceived behavioural control of the behaviour (how much self-efficacy one has over the behaviour and how confident ones feels about being able to do it).

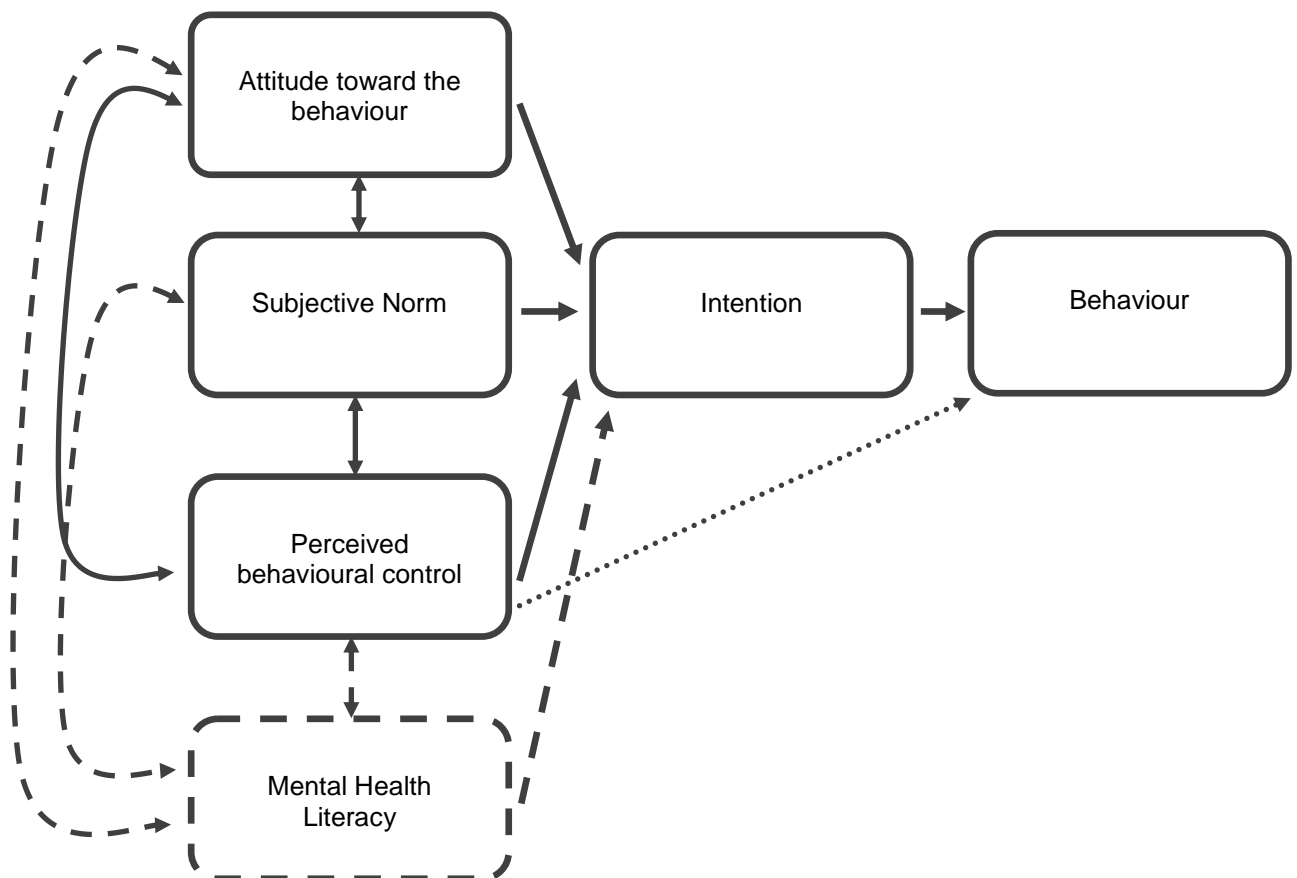


Figure 1: The Theory of Planned Behaviour

All three variables in the model influence one another. Ajzen (1991) notes that perceived behavioural control can be used to directly predict behaviour (depicted by the dotted arrow) as difficulties in carrying out the behaviour or being less confident in the ability to carry out the behaviour make it less likely for the behaviour to occur.

Mental health literacy (MHL) is defined as “the knowledge and beliefs about mental disorders which aid their recognition, management or prevention” (Jorm et al., 1997, pp. 182). Numerous studies have found that males tend to have a lower MHL level than females, recognising mental health problems less often in vignettes than their female counterparts (Coles & Coleman, 2010; Klineberg, Biddle, Donovan, & Gunnell, 2011; Melas, Tartani, Forsner, Edhborg, & Forsell, 2013; Swami, 2012). Poor MHL has been identified as a barrier to psychological help-seeking in a systematic review by Gulliver, Griffiths and Christensen (2010), and MHL interventions have been linked to improved help-seeking attitudes in a systematic review by Gulliver, Griffiths, Christensen and Bower (2012). To date, no study has been identified that incorporates MHL literacy into the TPB. However, one of the aims of the current study will be to investigate the relationship between MHL and the rest of the TPB, as depicted using the dashed arrows in Figure 1 above.

2.2.4 The Evidence Base for the TPB

The TPB has been used to examine a diverse number of different behaviours, such as teleconference use amongst office workers (Lo, van Breukelen, Peters, & Kok, 2014), aggression and weapon carrying (Finigan-Carr, Cheng, Gielen, Haynie, & Simons-Morton, 2015), and Facebook users' privacy protection (Saeri, Ogilvie, La Macchia, Smith, & Louis, 2014). In health research its application has also been widespread, from looking at fruit and vegetable consumption (Kothe & Mullan, 2015) to alcohol use (Hasking & Schofield, 2015). Brubaker and Wickersham (1990) used the TPB as a framework to explore young men's testicular self-examination and found intention was correlated with attitudes, subjective norms and self-efficacy. Armitage and Conner (2001) conducted a meta-analysis of 185 studies that used the TPB found that the model accounted for 27% and 39% of the variance in behaviour and intention respectively. More recently the TPB has been applied to psychological help-seeking in China (Mo & Mak, 2009; Mak & Davis, 2014). Both studies found that attitude, subjective norm and perceived behavioural control significantly predicted help-seeking intention. However, to date, only one study has used it to look at psychological help-seeking in men (Smith et al., 2008).

In their study, Smith et al. (2008) found support for a mediating effect of attitudes toward psychological help-seeking in men on the relationship

between traditional masculine ideology and psychological help-seeking intentions. Therefore, although it was based on the TPB the study did not examine the full model including subjective norms and perceived behavioural control. This is a limitation noted by the authors who suggest “examination of the impact of other TPB variables ... would allow a more comprehensive evaluation” (pp. 189) of the theory. Participants in the study were all from the USA, the majority Caucasian, and all undergraduates, leaving the question of whether the results apply to British men or men of different age groups, educational levels, and ethnic groups unanswered.

2.2.5 Rationale and Aims of Current Study

On the basis of the evidence currently available, it is clear that a better understanding of men’s help-seeking is required, especially for mental health difficulties. The TPB could be a helpful framework in which to better understand men’s help-seeking but current research in the area is limited.

The current study aimed to build upon Smith et al.’s (2008) study by including the subjective norms and perceived behavioural control components of the TPB model, as the role played in men’s psychological help-seeking is currently unknown. The present study also took the opportunity to expand the TPB and add MHL, by exploring its relationship with the other variables of the model.

As previously noted, other studies have found that GRC and masculinity are salient factors in men's psychological help-seeking (e.g. Smith et al., 2008). However, as extensive research has previously focused on this, it was not deemed an appropriate focus for the current study, where the focus was on trying to account for attitudes, subjective norms, perceived behavioural control and MHL and how these variables relate to psychological help-seeking intentions in men.

The study seeks to answer the following questions:

1. For which form of mental health problem are men most likely to seek help?
2. For mental health problems in general, which form of help-seeking source are men most likely to turn to for support?
3. Which is the most popular help source for particular mental health problems for men?
4. In terms of men's behavioural beliefs, do they view seeking help from professionals for psychological problems as a worthwhile action to take?
Are these beliefs held across different age groups?
5. In terms of men's normative beliefs, do they tend to stigmatise psychological problems? Are these beliefs held across different age groups?

6. In terms of men's control beliefs, do they tend to emphasise a degree of perceived self-efficacy about the intention to seek help? Are these beliefs held across different age groups?
7. In terms of men's mental health literacy, do they tend to emphasise a degree of accurate knowledge about mental health problems? Are these beliefs held across different age groups?
8. How well is the theory of planned behaviour model able to predict professional help-seeking intentions in men?
9. Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

2.3 Method

2.3.1 Ethics Application Process

Before the current study was conducted, ethical approval was sought and granted by the Coventry University Ethics Board. Project number: P37770 (see appendix E for ethics certificate). Participants were a non-clinical sample recruited via the Internet, who were asked to complete an online survey hosted by the Bristol Online Survey website. The British Psychological Society's (2013; 2014) Ethics guidelines for Internet-mediated research and Code of Human Research Ethics were adhered to. Background information regarding the study was displayed on the first page of the online survey, followed by a consent form which participants had to mark to show they gave their consent before the questionnaire was

displayed. A debrief page was displayed at the end of the study, along with information about websites and help lines where participants could seek help if they required (see appendix F for full questionnaire).

2.3.2 Research Design

Adopting a positivist methodological approach, the current study employed a within groups quasi-experimental survey design. Survey designs have a number of advantages, such as allowing for a large number of cases to be examined with a large number of variables, so that variation between them can be established (Barker, Pistrang & Elliott, 2012).

2.3.3 Participants

Table 1: Inclusion and exclusion criteria

Criteria	Inclusion	Exclusion
Gender	Males	Females
Age	18-65	<18 and >65
Ethnicity	All	None
Education level	All	N/A
Sexuality	All	N/A
Language	English	Non-English speakers

The inclusion and exclusion criteria for participants are displayed in Table 1 above. The study's participants represented a purposive sample of men living in the UK aged between 18 and 65. All participants were asked for

their age, ethnicity, education level and sexuality. Finally, it was expected that all participants would have a good level of English in order to complete the questionnaires.

Participants were recruited online by having the survey hosted using the Bristol Online Survey Tool and the link to the survey posted on a variety of platforms such as Twitter, Facebook and discussion boards which may be frequented by men on a variety of topics e.g. sport, health etc. Participants were encouraged to share the link to the survey with their social networks to enable snowball sampling. Francis et al. (2004) note that a sample size of at least 80 is acceptable for studies using the TPB.

2.3.4 Measuring Instruments

The study used an online questionnaire which comprised of three measuring instruments designed to measure aspects of the TPB, which have been used in previous studies. Some studies using the TPB create their own questionnaires to collect their data, based on guidelines by Ajzen (1991) and Francis et al. (2004), since there is no standard TPB questionnaire as each study using it will be looking at different types of behaviour. The disadvantage to this method is that it is time consuming to construct a TPB questionnaire as the process involves an initial qualitative elicitation study and subsequent question revisions. Each TPB questionnaire is therefore only used in the study for which it was created

and may have less reliability and validity than other standardised questionnaires. For this reason, previous questionnaires that measure components of the TPB were used in the present study and have already been validated in previous studies. Finally, relevant demographic data was collected (see appendix F).

2.3.4.1 General Help-Seeking Questionnaire - Vignette Version (GHSQ-V, Wilson, Deane, Ciarrochi, & Rickwood, 2005)

This questionnaire consists of 7 vignettes of short descriptions of people experiencing symptoms of mental difficulties such as stress, depression and psychosis, and one physical health problem (signs of a heart attack), to act as a control. It asks participants on a scale of 1 to 7 how likely it is they would seek help from a number of different people ranging from friends and family to different professional groups such as a GP or mental health practitioner, including 'I would not seek help from anyone'. The questionnaire also includes a mental health literacy question, asking participants to write what they think is 'wrong' with the person described in the vignette and if they think they need help. Reliability measures indicate $\alpha = .85$ and test-retest reliability of .92. For the present study $\alpha = .96$.

For the purposes of the present study, the scale for the responses was changed to a scale of 1 to 6, in order to eliminate a midpoint. The female names used in the original version were changed to male names, as it may have been possible that men may have answered differently if they

believed it was a woman experiencing the difficulties. The question 'I would not seek help from anyone' was rephrased to read 'I would seek help from someone', in order to measure participants' confidence or perceived self-efficacy of being able to seek help.

2.3.4.2 Perceived Devaluation-Discrimination Scale (PDD, Link et al., 1989)

The scale consists of 12 items, 6 of which are reverse scored which measures stigma. Participants are required to rate from 6 options how much they agree or disagree with statements such as 'most people would willingly accept a former psychiatric patient as a friend' and 'most employers would pass over the application of a former psychiatric patient in favour of another applicant'. Internal consistency has been reported to be between .72 and .88. For the present study $\alpha = .89$.

For the purposes of the current study, some of the language was changed to reflect modern day terminology, for example instead of 'former psychiatric patient' the phrase 'someone who has experienced mental health difficulties' was used.

2.3.4.3 Attitudes Toward Seeking Professional Psychological Help - Short Form (ATSPPH-SF, Fischer & Farina, 1995)

The scale consists of 10 items, 5 being reverse scored. Questions include 'I would want to get psychological help if I were worried or upset for a long period of time' and 'a person should work out his or her own problems; getting psychological counselling would be a last resort'. Participants are required to give a number from 0 (disagree) to 3 (agree) with partly disagree/agree as number 1 and 2. The scale has good internal consistency ($\alpha = .86$), acceptable test-retest reliability ($r = .73-.89$) and has been used in a number of studies on psychological help-seeking and has been further validated and deemed reliable by Elhai, Schweinle and Anderson (2008). For the present study $\alpha = .85$. For the purposes of the current study, the scale was changed from 0-3 to 1-4 to make it consistent with the rating scales on other measures used.

2.3.5 Data Analysis

Quantitative data from these measures were downloaded from the Bristol Online Survey website and exported into and analysed using IBM SPSS Statistics Version 24. A series of inferential statistical tests were used, including within groups ANOVAs, between groups one way ANOVAs, and standardised multiple regression. Details regarding the assumptions used for the analysis of questions 1-3 and 8 can be found in appendix G. For the first three aims, in order to investigate where the differences occurred in the data, a Pairwise Comparisons test was conducted to determine which

specific means differed. As some of the assumptions had been violated the significance mean difference value was set at the $p < .001$ level. See appendix H for an example of the SPSS output from aim 9.

2.4 Results

2.4.1 Demographic Information

A total of 236 participants completed the questionnaire. The ages of the participants ranged from 18-64, with a mean age of 41.10 years ($SD = 12.131$).

Table 2: Ethnicity of Participants

		What ethnic group do you belong to?			
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	White - British	206	87.3	87.3	87.3
	White - Irish	9	3.8	3.8	91.1
	White - Other White	14	5.9	5.9	97.0
	Mixed - White and Black Caribbean	1	.4	.4	97.5
	Asian or Asian British - Indian	2	.8	.8	98.3
	Black or Black British - Caribbean	1	.4	.4	98.7
	Chinese or other ethnic group - Chinese	1	.4	.4	99.2
	Chinese or other ethnic group - Other ethnic group (please specify)	2	.8	.8	100.0
	Total	236	100.0	100.0	

In terms of ethnicity, the majority of participants (87.3%) identified themselves as White British. See Table 2 for the complete statistics for ethnicity.

Table 3: Highest Level of Education Achieved

What is the highest level of education you have had?					
		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	GCSEs	13	5.5	5.5	5.5
	NVQs	15	6.4	6.4	11.9
	A Levels	27	11.4	11.4	23.3
	Undergraduate Degree	96	40.7	40.7	64.0
	Master's Degree	49	20.8	20.8	84.7
	Doctorate	36	15.3	15.3	100.0
	Total	236	100.0	100.0	

For sexual orientation, 84.3% of participants identified as heterosexual, 9.3% identified as gay, and 6.4% identified as bisexual. With regard to the highest level of education achieved, most participants (40.7%) reported having completed an undergraduate degree. Level of education statistics are outlined in Table 3.

2.4.2 Aim 1: For Which Form of Mental Health Problem are Men Most Likely to Seek Help?

The aim of this question was to examine which mental health difficulty is most likely to encourage men to contact any type of informal (e.g. partner) or formal (e.g. GP) help source.

Table 4: Matrix Format Illustrating Output from GHSQ-V for Aim 1

	Stress	Anxiety	Depression	Suicidal	Alcoholic	Psychosis	Heart	TOTAL
Partner	*							
Friend								
Parent								
Relative								
MHP								
Helpline								
GP								
Religious								
TOTAL	TotalHS stress	TotalHS anxiety	TotalHS depression	TotalHS suicidal	TotalHS alcoholic	TotalHS psychosis	TotalHS heart	

*Each cell contains participant responses on a 6 point likert scale

To investigate this question, data from the GHSQ-V was used (the matrix format underlying the output from the questionnaire is illustrated in Table 4). For each of the seven vignettes a total score was calculated, which combined the scores given for each of the eight types of help-seeking source (as illustrated by the shaded areas in Table 4). A repeated measures ANOVA was used to investigate the dependant variable (DV) of help-seeking intentions and the independent variable (IV) of mental health conditions (each topic of the 7 vignettes).

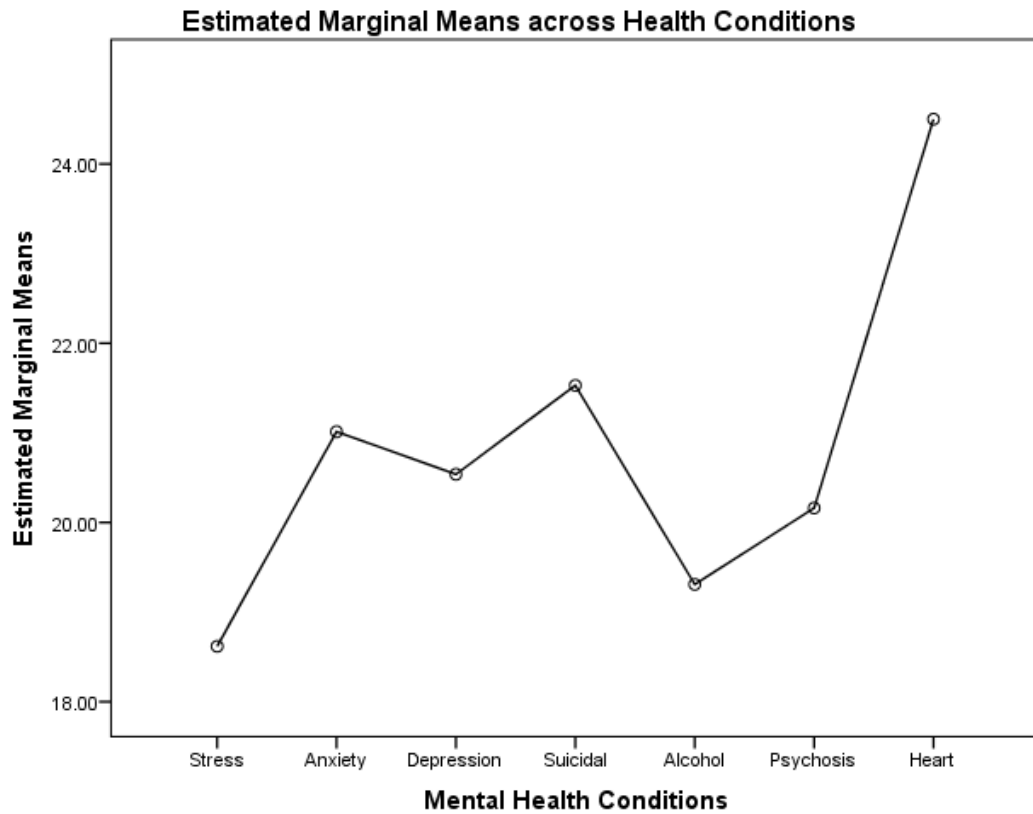


Figure 2: Estimated Marginal Means across Health Conditions

Figure 2 visually illustrates the differences between the means. The results suggest it is more likely for men to endorse seeking help for a heart attack (condition 7) compared to any mental health condition ($p \leq 0001$ for all conditions). Stress (condition 1) and alcohol abuse (condition 5) are the conditions men are least likely to endorse seeking help for. Participants were more likely to endorse seeking help for suicidal thoughts than stress, alcohol problems and psychosis, but not anxiety or depression.

2.4.3 Aim 2: For Mental Health Problems in General, Which Form of Help-Seeking Source are Men Most Likely to Turn to for Support?

The aim of this question was to investigate which particular help-seeking source (both informal and formal) men would be more likely to contact irrespective of the mental health problems they may have.

Table 5: Matrix Format Illustrating Output from GHSQ-V for Aim 2

	Stress	Anxiety	Depression	Suicidal	Psychosis	Alcoholic	Heart	TOTAL
Partner	*							TotalMH partner
Friend								TotalMH friend
Parent								TotalMH parent
Relative								TotalMH relative
MHP								TotalMH mhp
Helpline								TotalMH helpline
GP								TotalMH GP
Religious								TotalMH religion
Total								

*Each cell contains participant responses on a 6 point Likert scale

To investigate this question data from the GHSQ-V was used (the matrix format underlying the output from the questionnaire is illustrated in Table 5). For each of the eight help-seeking sources across the seven vignettes, a

total score was calculated (as illustrated by the shaded areas in Table 5). A repeated measures ANOVA with a Greenhouse-Geisser correction was used to examine whether there is any significant difference between the means of each of the total scores. (DV= help-seeking intentions, IV= help sources).

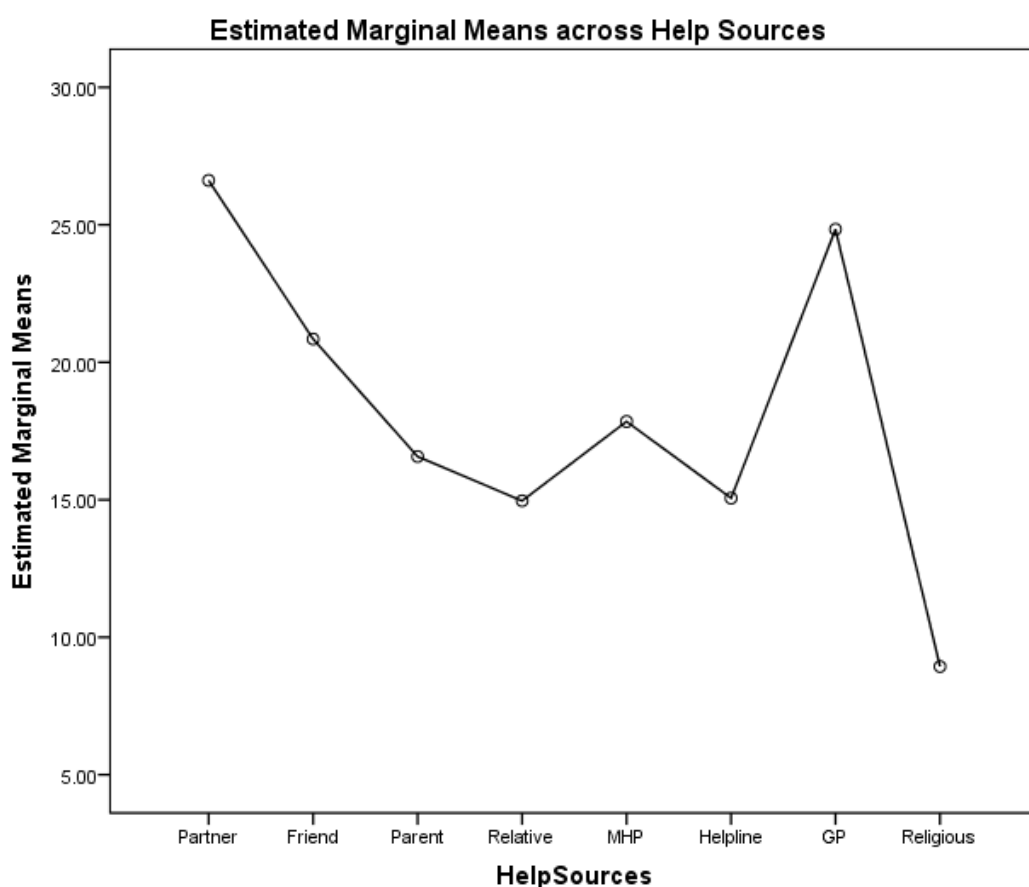


Figure 3: Estimated Marginal Means across Help Sources

Overall, the mean scores for help-seeking intentions were significantly different ($F(5.720, 1344.166) = 176.354, p \leq .0001$, Partial $\eta^2 = .429$). Figure 3 visually illustrates the differences between the means. A Pairwise Comparisons test shows that irrespective of mental health difficulty, religious leaders are the least popular help source. The most popular help

sources are intimate partner and GP, with no significant difference between the two ($p = .055$). Although the data shows men would rather contact a Helpline than a religious leader, this is not a very popular source of help. Also of note is that friends seem to be a more popular source of help, at least in the first instance, than mental health practitioners.

2.4.4 Aim 3: Which is the Most Popular Help Source for Particular Mental Health Problems for Men?

The aim of this question was to examine each mental health difficulty used in the GHSQ-V in order to determine which particular help-seeking source, both formal and informal, men would be more likely to contact.

Table 6: Matrix Format Illustrating Output from GHSQ-V for Aim 3

	Stress	Anxiety	Depression	Suicidal	Psychosis	Alcoholic	Heart	TOTAL
Partner	*							
Friend								
Parent								
Relative								
MHP								
Helpline								
GP								
Religious								
Total								

*Each cell contains participant responses on a 6 point Likert scale

The matrix format underlying the output from the questionnaire is illustrated in Table 6. The DV is help-seeking intentions and the IV is the help source, for each mental health condition in turn. A repeated measures ANOVA was run 7 times, one for each of the 7 vignette data.

Table 7: Mean (and standard deviation) scores for each help-seeking source across all 7 health difficulties

	Stress	Anxiety	Depression	Suicidal	Alcohol	Psychosis	Heart	TOTAL
Partner	3.88 (1.56)	4.18 (1.68)	3.91 (1.76)	3.44 (1.96)	3.32 (1.72)	3.18 (1.91)	4.69 (1.67)	26.6
Friend	3.02 (1.53)	3.02 (1.54)	2.95 (1.61)	2.89 (1.79)	3.06 (1.61)	2.42 (1.59)	3.48 (1.83)	20.84
Parent	2.28 (1.42)	2.44 (1.59)	2.19 (1.52)	2.11 (1.63)	2.02 (1.49)	2.36 (1.70)	3.17 (1.98)	16.57
Relative	2.01 (1.24)	2.06 (1.30)	1.99 (1.31)	2.10 (1.60)	2.05 (1.40)	2.06 (1.46)	2.71 (1.81)	14.98
MHP	2.13 (1.42)	2.58 (1.59)	2.83 (1.69)	3.25 (1.88)	2.28 (1.56)	3.15 (1.90)	1.63 (1.20)	17.85
Helpline	1.61 (1.12)	1.90 (1.39)	1.99 (1.50)	2.76 (1.85)	2.26 (1.61)	2.25 (1.60)	2.29 (1.83)	15.06
GP	2.44 (1.51)	3.54 (1.67)	3.38 (1.71)	3.60 (1.93)	3.04 (1.70)	3.48 (1.93)	5.35 (1.19)	24.83
Religious	1.26 (.87)	1.30 (.94)	1.29 (.96)	1.38 (1.11)	1.28 (.93)	1.26 (.98)	1.18 (.71)	8.95
Total	18.63	21.02	20.53	21.53	19.31	20.16	24.5	

Table 7 summarises the mean (and standard deviation) scores for each help-seeking source across the seven health difficulties. The results show that the mean scores across the eight different help-seeking sources for stress ($F(5.429, 1275.752) = 120.277, p \leq .0001$, Partial $\eta^2 = .339$), anxiety ($F(5.990, 1407.610) = 133.885, p \leq .0001$, Partial $\eta^2 = .363$), depression ($F(5.900, 1386.453) = 110.906, p \leq .0001$, Partial $\eta^2 = .321$), suicidal

($F(5.498, 1291.926) = 75.720, p \leq .0001$, Partial $\eta^2 = .244$), alcohol problems ($F(5.897, 1385.817) = 74.173, p \leq .0001$, Partial $\eta^2 = .240$), psychosis ($F(5.519, 1296.850) = 73.217, p \leq .0001$, Partial $\eta^2 = .238$), heart problems ($F(5.215, 1225.529) = 259.873, p \leq .0001$, Partial $\eta^2 = .525$) were significantly different.

The Pairwise comparisons tests show that for stress, anxiety and depression, men are significantly more likely to seek help from an intimate partner ($p \leq .0001$) than any other help source. For suicidal thoughts men are significantly more like to seek help from their GP, their intimate partner, or a mental health professional ($p \leq .0001$) than any other help source. However, there was no significant difference between mental health professional and friend ($p = .75$), which was the fourth most popular choice. For psychosis, men are significantly more like to seek help from their GP, their intimate partner, or a mental health professional ($p \leq .0001$) than any other help source. For alcohol problems, men are significantly more likely to seek help from their GP, intimate partner, or a friend ($p \leq .0001$) than any other help source. Finally, for a heart attack, men are significantly more likely to seek help from their GP ($p \leq .0001$) than any other help source.

2.4.5 Aim 4: In terms of men's behavioural beliefs, do they view seeking help from professionals for psychological problems as a worthwhile action to take? Are these beliefs held across different age groups?

This question links to the 'attitude toward the behaviour' part of the TPB. It was measured using the total scores on the ATSPPH, where participants could score between 10 and 40, with higher scores indicating a more positive view about the need to seek professional help for psychological problems. Age was re-coded into a categorical variable (18-29, 30-39, 40-49, 50+) in order to determine if these beliefs are evenly held across different age groups. A between groups ANOVA was then conducted.

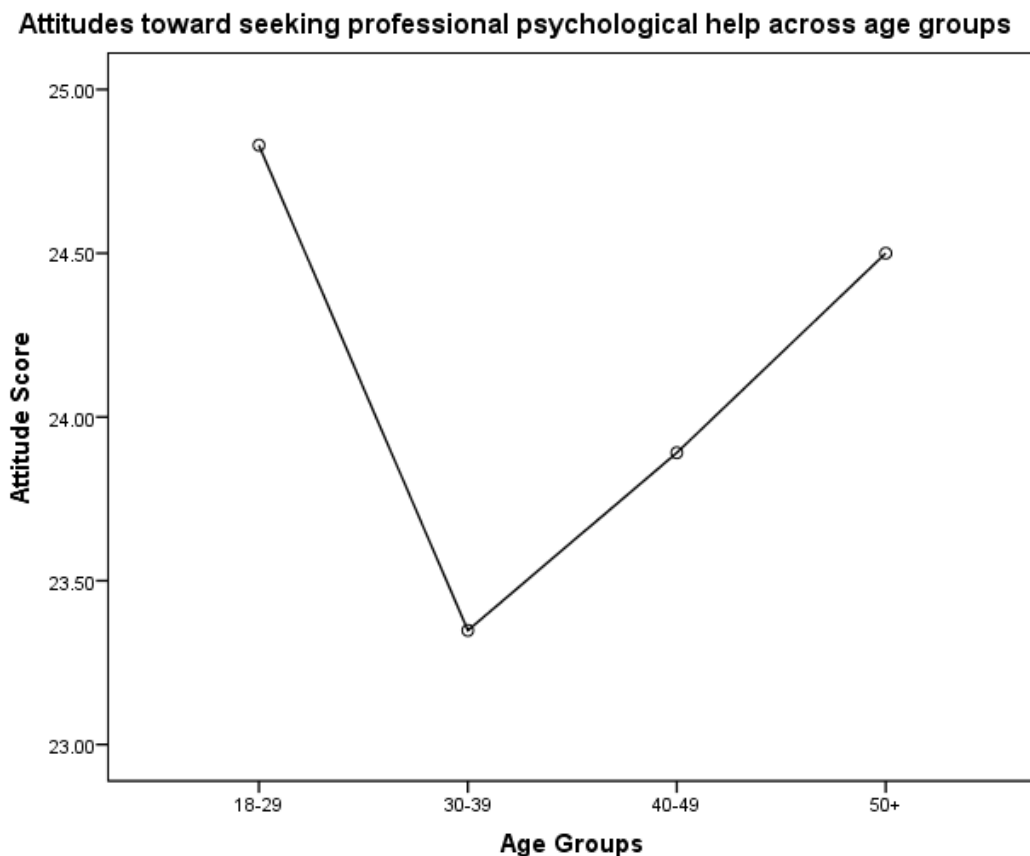


Figure 4: Means plot for attitudes toward seeking professional psychological help across age groups.

The mean score was 24.1, which suggests a general agreement with the behaviour belief in seeking help. The data is reasonably normally distributed (skewness = -.550, kurtosis = 2.043). The means plot for the between groups ANOVA conducted across the age groups is displayed in Figure 4. The ANOVA data shows that there is a significant difference in mean attitudes toward seeking professional psychological help scores between the different age groups ($F(3, 232) = 2.729, p = .045$). The Tukey HSD statistic was used in order to locate differences between groups. This showed that no paired comparisons are significant. Between age groups 1 and 2 $p = .055$, between age groups 1 and 3 $p = .406$, between age groups 1 and 4 $p = .940$, between age groups 2 and 3 $p = .762$, between age groups 2 and 4 $p = .128$, and between age groups 3 and 4 $p = .687$.

The patterns in the data show that for group 1, the youngest age group (18-29), there appears to be a more favourable attitude to seeking psychological support. The second age group (30-39) seems to have the least favourable attitudes toward seeking psychological support, with attitudes becoming more favourable again in the 40-49 year olds. This is further increased in the oldest age group, who seem to have favourable attitudes toward psychological help-seeking.

2.4.6 Aim 5: In terms of men's normative beliefs, do they tend to stigmatise psychological problems? Are these beliefs held across different age groups?

This question links to the 'subjective norm' part of the TPB. It was measured using the PDD, where participants could score between 12 and 72. A lower score indicates a lower level of stigma. To determine if these beliefs are evenly held across different age groups a between groups ANOVA was then conducted using the age group categories previously coded.

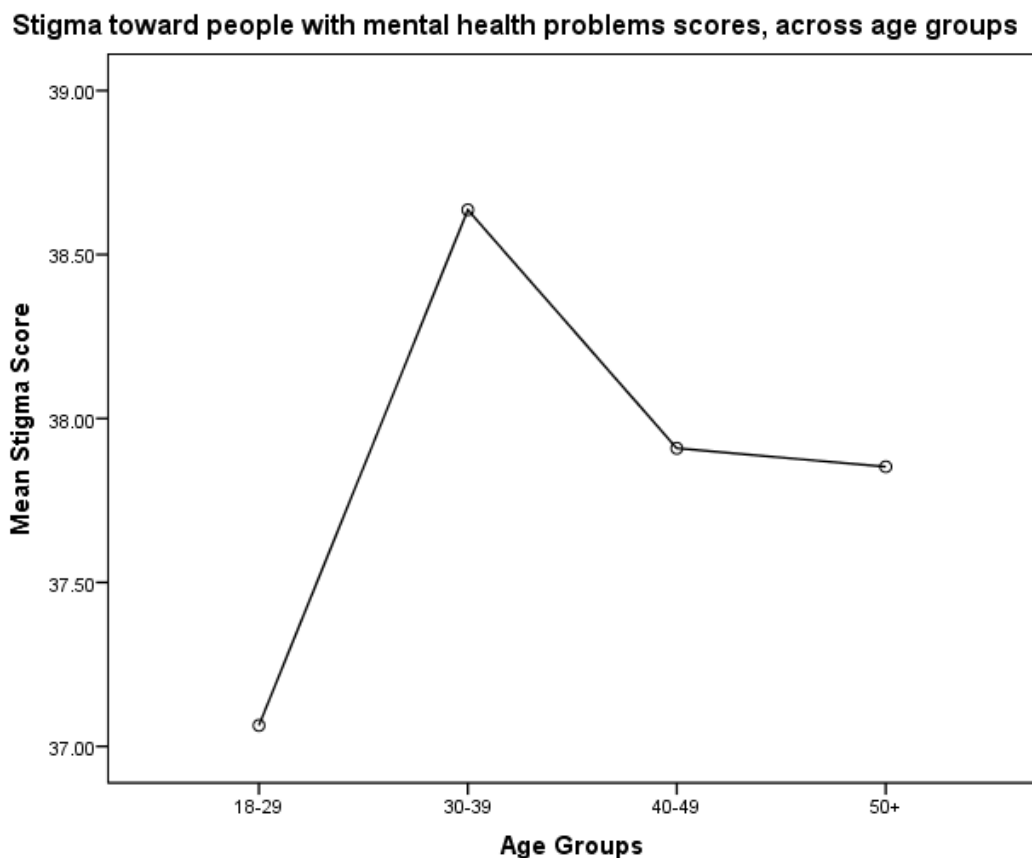


Figure 5: Means plot for stigma toward people with mental health problems across age groups.

The mean score of 37.9 suggests neither a positive nor negative level of stigma in the participants as a whole. The data is reasonably normally distributed (skewness = -.357, kurtosis = .401). The means plot for the between groups ANOVA conducted across the age groups is displayed in Figure 5.

Overall, the results show that there is no significant difference in mean scores of stigma toward people with mental health problems between the different age groups ($F(3, 232) = 1.139, p = .334$), which suggests that age does not influence levels of stigma. Although the means in Figure 5 suggest that the second age group (30-39) hold higher levels of stigma.

2.4.7 Aim 6: In terms of men's control beliefs, do they tend to emphasise a degree of perceived self-efficacy about the intention to seek help? Are these beliefs held across different age groups?

This question links to the 'perceived behavioural control' component of the TPB. As the essence of this is around one's confidence or perceived self-efficacy of being able to perform the behaviour, it was felt this would be captured by the statement "I would seek help from someone" in the GHSQ-V, across the 6 vignettes that focused on mental health issues. Scores could range from between 6 and 36. A lower score indicates low level of control. To determine if these beliefs are evenly held across different age

groups a between groups ANOVA was then conducted using the age group categories previously coded.

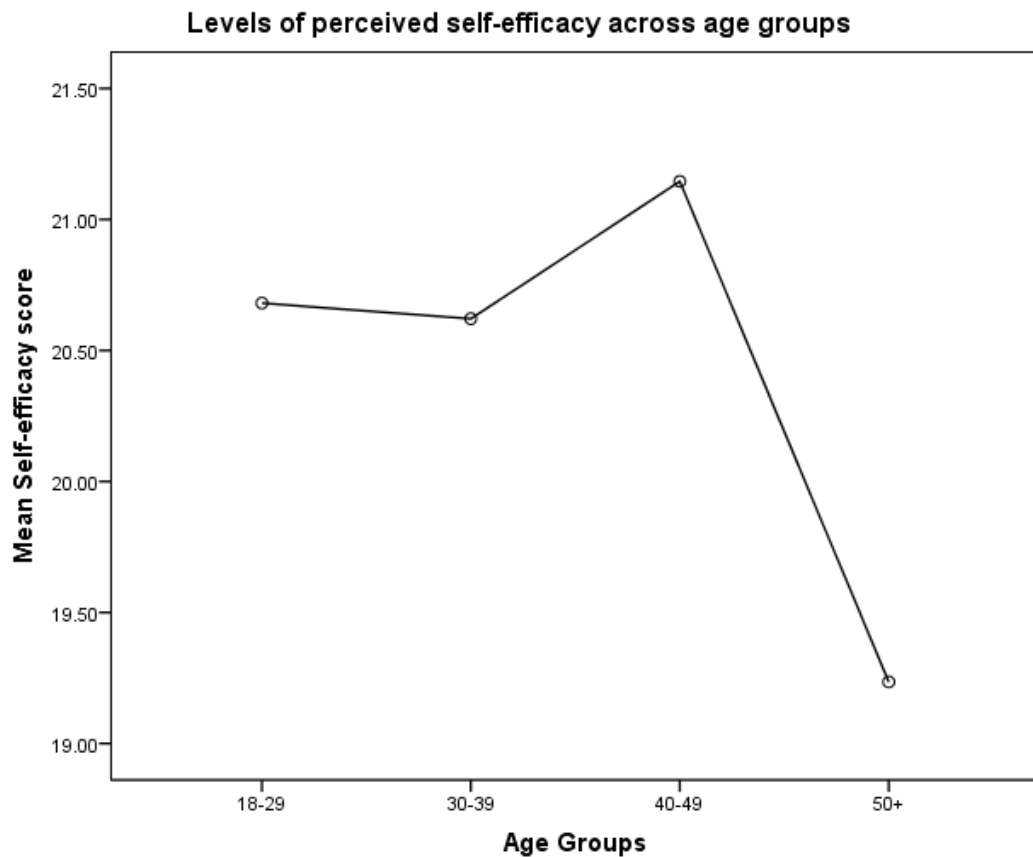


Figure 6: Means plot for level of perceived self-efficacy across age groups.

The mean score of 20.3 suggests neither a positive or negative level of control. The data is reasonably normally distributed (skewness = 0.36, kurtosis = -.949). Overall, the results show that there is no significant difference in mean scores of perceived self-efficacy between the different age groups ($F(3, 232) = .603, p = .614$). This suggests that age has no influence on levels of control beliefs. However, the means plotted in Figure 6 suggests that the eldest age group (50+) have the least control.

2.4.8 Aim 7: In terms of men's MHL, do they tend to emphasise a degree of accurate knowledge about mental health problems? Are these beliefs held across different age groups?

This question was measured using participants' answers in the six case vignettes regarding mental health (the 7th physical health vignette was not used), which asked them to identify what they thought was wrong with the person. The text responses to the questions were coded into a scale from 1-4 based on the accuracy of the answer, with 1 representing 'inaccurate' (i.e. stating there was nothing wrong at all with the person), 2 representing 'mostly inaccurate' (i.e. stating something was wrong, but not knowing what), 3 representing 'mostly accurate' (i.e. a mental health problem other than the 'correct' answer), and 4 representing 'accurate'. Therefore, the scores can range between 6 and 24; a lower score indicates a lower level of MHL. To determine if these beliefs are evenly held across different age groups a between groups ANOVA was then conducted using the age group categories previously coded.

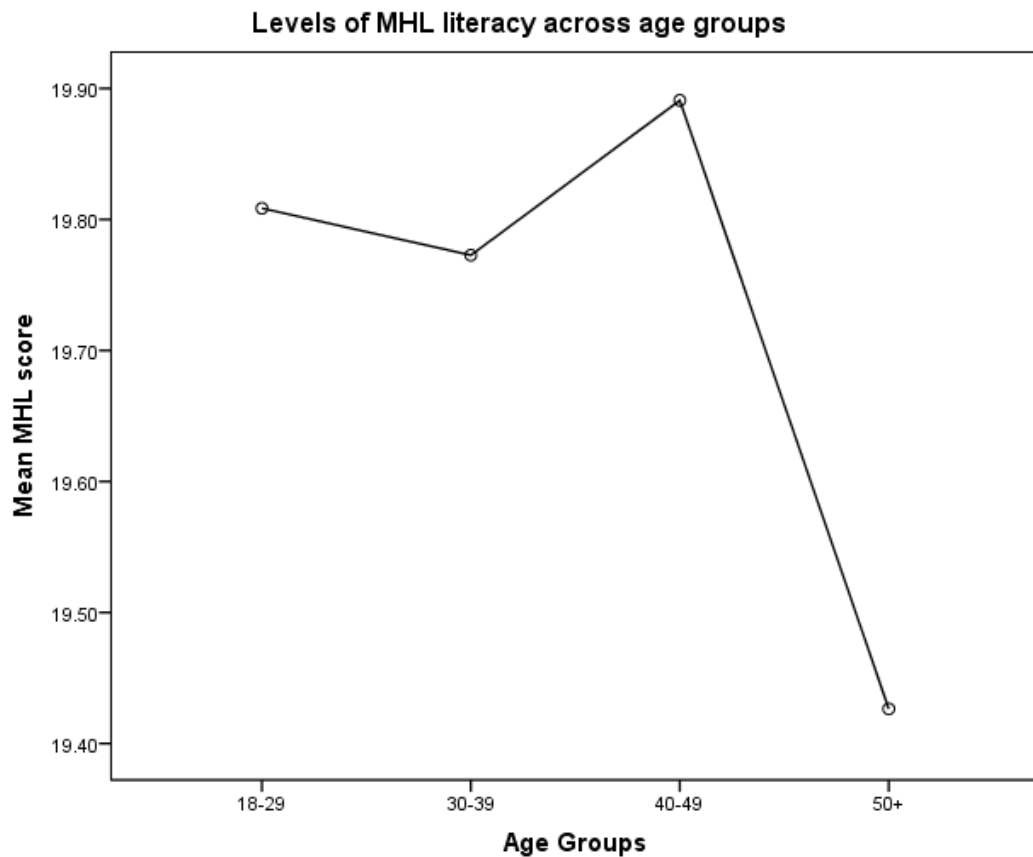


Figure 7: Means plot for level of MHL across age groups

A mean score of 19.7 suggests a very high level of MHL. The data is not normally distributed (skewness = $-.530$, kurtosis = 2.226). Overall, the results show that there is no significant difference in mean scores of mental health literacy between the different age groups ($F(3, 232) = 456, p = .713$), suggesting that age has no influence on levels of MHL. However, the data in the plot in Figure 7 suggests that the eldest age group (50+) have the lowest levels of MHL.

2.4.9 Aims 8&9: How well is the TPB model able to predict professional help-seeking intentions in Men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

To analyse this question the main DV was help-seeking intentions, which was measured by the participants' responses on the GHSQ-V in relation to the likelihood of seeking help from professional help-seeking sources (GP, mental health professional, and telephone helpline). A standard multiple regression was then conducted, using the continuous DV and the three continuous IVs, which are total behavioural belief scores, total stigma scores and total control belief scores. The above model was then run again, adding the additional variable of MHL.

The data shows $R^2 = .532$. This suggests that the TPB model accounts for 53% of the variance in professional help-seeking intentions, for all forms of mental health help-seeking. Results from the ANOVA show that this relationship is significant ($F(4, 231) = 44.455, p \leq .0001$).

With regards to how much each of the variables contributed to this variance, it appears that perceived behavioural control (self-efficacy) variable ($\beta = .682, p \leq .0001$) makes the strongest unique contributed to explaining professional help-seeking intention in men in this model. Second, is attitudes toward seeking professional psychological help ($\beta =$

.139, $p = .03$), which is also a significant result. Stigma ($\beta = -.073$, $p = .109$) and MHL ($\beta = .023$, $p = .613$) were not significant.

Overall, control beliefs accounted for 44% of the variance and behaviour beliefs accounted for 1.8%. The data therefore suggest that it is mainly these two variables which are explaining most of the variance.

2.5 Discussion

The current study aimed to investigate whether the TPB could be used as a framework to provide a better understanding of help-seeking intentions in men, particularly for mental health difficulties. It focused on the variables of attitudes toward seeking professional psychological help, levels of stigma, perceived efficacy of seeking help, mental health literacy, and their correlation with each other. In addition, the data were examined to discover if there were differences in the likelihood of seeking help for different psychological difficulties, and if there were any differences in which sources of help were most likely to be endorsed by men. From the results, there are three principle issues which have arisen and will now be discussed: how useful the TPB is for explaining help-seeking for psychological difficulties in men; who men are most likely to seek help from; and masculinity in the context of help-seeking.

2.5.1 How useful is the TPB for Explaining Help-Seeking for Psychological Difficulties in Men?

When looking at seeking professional psychological help, the current study found that both attitudes toward seeking professional psychological help, and self-efficacy (perceived behavioural control) of seeking help, were the two variables that were significant in predicting intention. The former finding is consistent with Smith et al. (2008) who also found that attitudes toward psychological help-seeking was a significant factor in predicting help-seeking intentions in men for mental health difficulties. What the present study adds to the existing literature is that, for men, perceived behavioural control is also a significant factor in predicting psychological help-seeking, which accounted for most of the variance within the model. Ajzen (1991) has commented that this component can have a direct influence on behaviour, which is shown by the dotted arrow in Figure 1 on page 75 of this chapter.

However, there were two components, stigma and MHL that were not found to be significant in the current study. This is interesting because previous literature on the TPB has found stigma to be an important component of the model to predict intention to perform a number of behaviours (e.g. Lo et al., 2014). More specifically, when the TPB has been applied to help-seeking among Chinese people, studies by Mo and Mak (2009) and Mak and Davis (2014) found the stigma component to be significant. However, Chandrasekara (2016) found similar results to the current study, in that

stigma did not have a significant effect within the model, whereas attitudes and self-efficacy were found to be significant. It is possible that mental health stigma plays a more important role within men in Chinese society due to cultural differences, which have also been found when comparing Asian American to European American college students (Masuda & Boone, 2011). Alternatively, the differences could be due to the measures used to collect the data, as both the current study and that by Chandrasekara (2016) used standardised measures, whereas the two studies from China created new measures for their specific aims.

With regard to MHL, it is surprising that no significant effect was found. Although MHL was a component added to the TPB model by the current study, previous research suggests males tend to have lower levels of MHL (e.g. Melas et al., 2013) and that it is a barrier to psychological help-seeking (Gulliver et al., 2010). However, participants in the current study had an overall high level of MHL, which may be accounted for by their high education levels.

2.5.2 Who Do Men Seek Help From?

The results of the current study suggest that men do endorse seeking help for psychological difficulties, but primarily informally. For each of the psychological difficulties, men were significantly more likely to state they would seek help from their intimate partner. It is important to consider that

the reaction of the man's partner could greatly influence his next steps with regards to formal help-seeking. Although research in the area is limited, it has been found that partners and GPs influence men the most to seek professional psychological help (Cusack, Deane, Wilson, & Ciarrochi, 2004). However, the link between men seeking help from their intimate partner and the partner's influence on men then seeking help from their GP is currently unknown and would be a helpful area for future research to consider. Ajzen (1991) indicates that the subjective norm component of the TPB (in this case stigma related to psychological difficulties), is influenced by others around the individual. Therefore, partners and GPs may form a critical role in encouraging men to seek help for psychological difficulties. This finding also raises the question as to whom men who are currently not in a relationship, or who have experienced a relationship breakdown, may turn to. Interestingly, research suggests that relationship breakdown is more likely to lead to suicide in men, than in women (Wyllie et al., 2012). Whether men in these categories would seek support from their GP for mental health needs appears to be an area requiring further investigation in future research.

Scoping studies, such as White (2001) have found that some of the reasons men are reluctant to access health services are that the opening times do not fit with their work schedule and that they find it uncomfortable waiting around in services which they feel are primarily for women. It could be assumed that calling a helpline may be a way to access support without

these barriers. However, the results from the current study suggest that, of the help-seeking options presented in the current study, men are less likely to turn to a helpline for support. However, it is recognised that data on the utilisation and helpfulness of helplines for men is currently limited (Robertson et al., 2015).

2.5.3 Men, Masculinity and Help-Seeking.

Although the literature has noted that men tend to seek help less for physical (e.g. Wang et al., 2013) and psychological (e.g. Oliver et al., 2005) difficulties, this is usually discussed in comparison to women. What the current study adds to existing literature is that men in this study are significantly more likely to endorse seeking help for a potentially serious physical health condition (signs of a heart attack), than for any form of psychological difficulty, including suicidal thoughts and signs of psychosis. Reasons for this could be considered within the framework of *hegemonic masculinity*, which is a term used to define the dominant form of masculinity acceptable within a patriarchal culture (Connell, 2005). Within the UK, being male and masculine is often equated to being independent, powerful, physically strong and almost invincible (Newman, 1997). When faced with a serious physical health concern, a man may have little option but to seek medical attention. However, when experiencing psychological difficulties the man's concept of hegemonic masculinity may come into play, where he feels he has to be strong and independent, which he equates to not seeking help and not relying on others. By not visiting a doctor and by taking risks, a

man can then legitimise himself as being part of the 'stronger' sex and displaying his masculinity (Courtenay, 2000). This indicates that the TPB needs to be sensitive to the issues of gender, and reinforces existing findings by Smith et al. (2008). However, further research investigating the links between gender and the other TPB components is required. It is also important to consider that concepts of masculinity differ across cultures (Connell, 2005) and that men from ethnic minority groups tend to have poorer health and poorer access to health services (Iqbal & Harrison, 2008), while at the same time being over represented amongst those who are involuntarily detained in mental health hospitals (HCSIC, 2015). This suggests that masculinity and culture are areas that could be beneficial for services and future research to consider.

2.5.4 Clinical Implications

There are a number of services that have attempted to engage men with mental health needs (a range are discussed in Kingerlee, Precious, Sullivan & Barry, 2014; Powell, 2010; Seager & Sullivan, 2016). Some of these services have created safe spaces that are accessible only to males, have targeted their services to men through different types of media, and have used male celebrity endorsements, with the aim of giving men a greater confidence about where and how to access support. These types of services and campaigns proactively seek to change men's attitudes toward seeking help by targeting the hegemonic masculinity and reformulating it, such that being strong, independent and masculine may change from

meaning “keeping calm and carrying on”, to instead being strong enough to be able to ask for support, to become “action man” and take back responsibility and control (Farrimond, 2011). The findings from the current study suggest that raising awareness in terms of masculinity’s role in help-seeking is extremely important, and these types of creative campaigns are starting that process.

Another clinical implication arising from the current study is the need for services to focus more on the link between formal and informal help-seeking sources for men. For all types of mental health problems presented in the study, men were most likely to endorse seeking help from their intimate partners. This raises the issue as to what services could do more in order to engage with the partners of men. It is possible that many of the new and creative ways of reaching out to men previously discussed will also reach their partners too; however, having promotional material aimed directly at partners may be another helpful avenue to pursue.

With regards to formal help-seeking, a further clinical implication is the need for services to focus on GPs and their role in referring men onto psychological services. Awareness training for GPs in men’s mental health and an evaluation of its effectiveness, or adopting previously successful strategies at engaging men in health (as discussed in Conrad & White, 2008; 2010) and applying them to GP settings would be worthwhile.

Finally, the findings from the current study also raise the issue as to how effective helplines are in meeting the needs of men with mental health difficulties, as men were less likely to endorse using a helpline to seek support. It may suggest that funding for helplines for men may be more helpful if spent in other areas, or by changing the way the helpline is advertised. Powell (2010) discusses how one helpline for men run by the Campaign Against Living Miserably (CALM) was branded “to look like anything but what it was” (p. 248), in order to try and encourage more men to use it. This kind of innovative branding has been helpful in engaging more men with mental health services.

2.5.5 Limitations

One limitation of the current study is that the participants are not representative of the UK male population, with 97% of the sample identifying as Caucasian, and 76.8% stating they are educated to an undergraduate degree level or higher. This may account for the high levels of mental health literacy found. Therefore the results may not be able to be generalised to men from different ethnicities and with different educational backgrounds. According to the Bristol Online Survey where the survey was hosted, there were over 100 people who started the survey but did not complete it. Most of the non-completers stopped during the first three questions, at the beginning of the vignettes. Perhaps if a shorter measure

had been used, the dropout rate would have been lower. However, a strength of the present study is that it was able to recruit over 200 men who completed the survey, especially as men have been found to be more difficult to recruit in research (Patel, Doku, & Tennakoon, 2003).

In line with aim 8 of the current study, the stigma (subjective norm) component of the TPB model was not significant. One reason for this could be due to the measure used. The authors of the PDD assert that socialisation leads one to develop beliefs about how others treat people with mental health problems, which can then lead them to believe they will be devalued and discriminated against if they had a psychological difficulty themselves (Link et al., 1989). However, a measure that asks participants directly how they feel they would be judged if they sought help for a psychological difficulty may yield a different result within the model.

A further limitation is that the 'perceived behavioural control' component of the model was only measured using a single question. It was felt that this question captured the participants' perceived self-efficacy. However, this could have been better represented by two or three questions, which would have increased the validity of the measure. As there is no pre-existing measure for this component additional questions would need to be created for future research.

The present study also employed vignettes as part of its methodology. Potential limitations to using vignettes in research are that the answers provided may only relate to the specific vignettes, participants may give socially desirable answers, or they may feel there is not enough information in the vignette to make a decision (Hughes & Huby, 2004). Therefore the results may not be generalisable. The study may have benefitted from testing the theory of planned behaviour fully using a newly created questionnaire specific to the needs of the study, following the process outlined by Francis et al. (2004).

Finally, although the quantitative methodology employed has many advantages; it did not allow men to freely discuss their views on help-seeking for psychological difficulties. Qualitative approaches have many advantages such as enabling the individual to be studied in depth and detail; they give more freedom to participants than quantitative methods, which may allow the researcher to discover something that was not originally being looked for (Barker et al., 2012).

2.5.6 Recommendations for Future Research

The area of men's psychological health and help-seeking is small but growing in size. A number of interesting possible directions have been identified in this study. Firstly, research into the role of intimate partners in the encouragement of men seeking professional help for psychological

difficulties would be advantageous, and may give services a different way of trying to access men. Secondly, further research focusing on GPs' roles in signposting men to psychological services would be beneficial, along with an evaluation of any mental health awareness training delivered to GPs.

Thirdly, men's views on using helplines as a means of gaining help for psychological difficulties may provide a reason why it was a lowly favoured option in the current study. Fourthly, the role of MHL and its potential role in the TPB could be explored in more detail with a more representative sample of men. A study with a larger scope could create its own questionnaire to measure each component of the TPB in relation to men's help-seeking for psychological support. Finally, evaluations of initiatives that aim to improve men's attitudes toward seeking professional psychological help and their knowledge and self-efficacy in relation to being able to access services would shed more light on what produces results clinically in terms of increasing men's access to psychology services (e.g. Seager & Sullivan, 2016).

2.6 Conclusion

The present study has suggested that the TPB can at least partially be used as a way of understanding psychological help-seeking in men. It appears that perceived self-efficacy in seeking help is the biggest predictor of men's intentions to seek help, but attitudes toward seeking professional

psychological help also play a role. These factors also need to be considered within the framework of hegemonic masculinity. Another important finding was that men are most likely to seek help from their intimate partners and GP, and least likely to from religious leaders and helplines. This has clinical implications for the promotion of men's health and many areas for future research have been suggested.

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Chapter 3: Reflections on being a male trainee clinical psychologist and researching the topic of men's mental health

This paper has not been prepared for submission to a journal

Chapter word count: 3,331 (excluding references)

3.1 Introduction

Clinical psychology has adopted a scientist-practitioner model to take an empirical approach to clinical work, since it first established itself in the 1940s (Youngson, 2009). Within this approach, emphasis is placed on clinical psychologists being able to evaluate and generate their own research, which adds to the evidence base, on which their clinical interventions are founded. In the 1980s the reflective-practitioner model was introduced (Schön, 1983). This model requires clinicians to stand back from their work and to reflect on what is happening, and has both cognitive and affective components (Youngson, 2009). Although these two models are based on two different epistemological paradigms, it is argued that not only can the two models be used together, but they can enhance one another (Whittaker, as cited in Youngson, 2009). Indeed, now in the UK, being able to use both the scientist-practitioner and reflective-practitioner models are part of the Standards of Proficiency for Practitioner Psychologists (Health & Care Professions Council, 2015). In this paper, I will take the stance of a reflective-practitioner in order to reflect on some of my experiences of working from the scientist-practitioner perspective with regard to: choosing a research topic for my doctoral thesis and what drew me to it; being a man working in a predominantly female profession; being a male trainee clinical psychologist; being a man and researching men's issues; writing about men; and finally, my thoughts about how the work started in this thesis can be continued post-qualification.

3.2 Choosing a Research Topic

Both of the chapters preceding this one examine the psychology of men and their help-seeking experiences, for either experiencing sexual abuse or mental health difficulties in general. I was first drawn to men's help-seeking as an area of research when I worked as a Psychological Wellbeing Practitioner within an Improving Access to Psychological Therapies (IAPT) service, before I commenced clinical psychology training. I noticed that the vast majority of the clients I was working with were female and was curious as to why this was. Nationwide, less than 32% of people referred to IAPT services are male (Health and Social Care Information Centre, 2015), demonstrating that improving accessibility to psychological therapies for men is still an issue. This curiosity led me to start reading more about the psychology of men. During this research, I was shocked to discover a number of facts about how men: make up the vast majority of suicides, of single homeless persons, of people addicted to drugs and alcohol, and of the prison population; have a lower life expectancy; do significantly worse in education; are significantly more likely to die at work or by violence; are significantly less likely to seek help of any kind; and are much less likely to choose a career in clinical psychology or other caring professions (Seager, Barry & Sullivan, 2016).

I attempted to do a literature search to find out what contribution psychology has made to the understanding of this problem and what can be done to help. Although some research was available it appeared that the

topic of men's psychology was relatively small, though growing. Seager et al. (2016) argue that clinical psychology colludes with the "male gender blindness" found in society. I felt this was something that needed to change, and I wanted to make a contribution to this. I remember talking enthusiastically about the topic at my clinical psychology doctorate interview, and three years later, after the challenges of the course and the thesis papers, I can say that my enthusiasm is even stronger.

3.3 Being a Man in a Predominantly Female Profession

As a result of this newfound enthusiasm and interest in men's psychology and help-seeking I started to consider my own gender and gendered experiences. I am aware that within this Western patriarchal society that I live, being a white man is something that comes with power and privilege. Indeed, being a white male can be seen as the dominant "norm", from which everything else differs (Addis, 2008). However, working and studying within the field of psychology has taken me into the position of being part of a minority group based on my gender. Working in an environment that is predominantly female has many positive qualities, and I have had the experience of being supervised by many empathic, caring, and extremely knowledgeable women, who I feel have invested time and energy to guide, mentor and nurture me into growing into the person and professional that I am today. However, being in the minority can at times feel isolating.

This has made me wonder how men who are on the other side of this, and are the ones accessing psychological services may feel. One thing some men state which makes them reluctant to access health services is that they feel they are primarily for women (White, 2001). Men accessing psychological services may have the experience of coming into a waiting area where the reception staff are female, the majority of other people waiting to be seen are female, the clinicians coming to collect their clients are female, and the magazines set out to pass the time are aimed at females. I wonder if they sometimes feel isolated too and if this could contribute to the lack of men accessing these services, and if more could be done to minimise this.

Being part of a minority myself at work has made me consider more deeply how it may feel for the clients I work with, and others generally, to be part of a minority group, especially one that is very visible, such as gender, race, or a visible disability. At the same time I hold in mind that my experience is different, especially since within the wider society I can be seen as one of the privileged majority. Yet I find it interesting that how an individual is perceived can differ across situations, along with their power and roles.

I also had the experience in my first job after graduating of being in a minority for both being male and white, where I worked on an acute mental health ward in East London, alongside colleagues who were predominantly

Afro-Caribbean women. These experiences further emphasised to me the importance of recognising and celebrating the wonderful differences that exist in society, rather than trying to see everyone as the same. When working with clients it has helped me to more carefully consider cultural, gender and systemic factors, such as with a man who lived with his wife and daughters, had few male friends and a poor relationship with his dad. Through my experiences and training I was able to look beyond just the symptoms of depression he was presenting with, and think about the impact his gender and the lack of contact he had with other males may have been having on his mood.

3.4 Being a Male Trainee Clinical Psychologist

In 2014, the year I was successful in gaining a place on the clinical psychology doctorate course, just 17% of people accepted onto one of these courses throughout the UK were male (Clearing House, 2014). I felt extremely lucky that I was part of the 40% of men in our cohort, a figure that appears to be unusually high. Guest trainers would often comment on how many men were in the room, something they were not used to seeing in their own cohort or in other psychology teaching they had facilitated. Anecdotally, I am aware of a number of clinical psychology cohorts that have no men in them at all. Among registered psychologists within the UK, only 20% are male (British Psychological Society, 2016). Therefore, this has been the first (and may perhaps be the only) time where I have been a

part of a more equal gender mix within psychology, which I have found very rewarding. I have not felt the pressure to function as a “representative male” as some male trainees have reflected on feeling in their cohorts (Baker, 2011). If a conversation ever focused on a particularly “feminine” topic that I had no knowledge of or interest in, then I had three other men I could speak with about something else. The other men in my cohort and I have also arranged a number of “guy’s nights” over the course of training (partly prompted by the fact that the women in my cohort were organising “girls’ nights”), which enabled us to bond. I feel that this is an experience not many male psychologists may get to have, and one which I have found to be incredibly valuable. Although as a cohort as a whole, we started as just ten trainees, I have felt we have a great mixture of backgrounds, experiences and personal qualities, which I feel has enabled me to get even more out of training through learning from their views and experiences.

On placement during training, I have had the experience of my increasing knowledge and awareness of men’s gender issues through research playing a role in a clinical intervention. I was working with a male client, whom other team members had thought would benefit from psychological support and had been trying to encourage him to engage in psychological therapy for a number of years, but he had always refused. However, during the time I was on placement within the team, he changed his mind and said he would like to engage in therapy. After meeting him informally he agreed

to commence sessions with me. During therapy, the client spoke about how he felt that his father needed some support, but that his father perceived seeking help as “weak” and an “unmanly” thing to do. I reflected back a wondering if this was a view the client himself had previously held, which he acknowledged he had. For me, I felt I could see some of the research findings around hegemonic masculinity and gender role norms played out before me, and it illustrated to me how these messages of masculinity can be passed down from father to son, i.e. that there is an intergenerational aspect to how men view themselves, and thus how they are likely to perceive help-seeking. We were then able to explore some of the reasons why the client changed his mind about seeking therapy, and how he was able to change his internal masculine script to one where being strong equates to seeking help before his difficulties get worse and begin to affect his relationships with others who are very important to him.

3.5 Being a Man and Researching Men’s Issues

Due to the fact I was interested in this area even before starting training, I was enthusiastic to turn this desire into a reality and to start conducting my thesis research. I have very much enjoyed doing some of the background reading on the topic and learning more about other practitioners who are passionate about men’s mental health. For example, the June 2014 issue of *The Psychologist* magazine was dedicated to the topic of male psychology, and more recently, in September 2016 the *Clinical Psychology*

Forum was dedicated to the issue of gender and featured articles on male psychology too. A number of psychologists have set up a male psychology network (www.malepsychology.org.uk), to promote the well-being of men and boys. Some of the same psychologists are also involved in hosting a Male Psychology Conference in London, which I hope to attend in the future. During the process of promoting my empirical study on social media I became aware of the existence of a number of organisations focussing on men's health and wellbeing, which I had not been aware of before, such as Men's Sheds, Andy's Man Club, the Mental Health Football Association, and the Campaign Against Living Miserably (CALM). I was enthused to find that the amount of awareness on the high suicide rate for men and men's mental health in general is being raised, and that others are recognising its importance and trying to make a difference.

Although I am passionate about the topic, it has not taken away from the fact that completing a doctorate in clinical psychology is not an easy process. Having to balance the roles of student, classmate, therapist, colleague, supervisee, and researcher with being a friend, son, brother and a human being can be very stressful. It has made me think about how I handle stress and seek help myself. I am fortunate that I have colleagues who live locally and have found them to be an immense form of support and I hope they have found the same in me. There were times that I found it helpful to share my stresses with them, especially as they could empathise

with me the most, since they were going through the same experience that I was.

However, there have also been times where I have felt the need to disconnect from others a little, in order to focus on my writing, whilst at the same time keeping self-care as a priority. I feel that in this final year I have explored my local parks and surroundings much more than in the previous two, as I am making sure I take regular breaks and greatly notice the benefits of doing so. I have also realised that compared to the process of writing my dissertation during my undergraduate degree, this time around I am utilising my research team more appropriately and asking for help and support when required and arranging regular meetings. Looking back on my undergraduate days, I only met my supervisor the minimum amount of times required by the course, however, with hindsight, I can see that my project would have been stronger if I had communicated better and asked for more support and feedback.

Perhaps the biggest motivating factor for me when I was feeling stressed or disheartened, was the response I received from people on social media once I started to share information about my study in order to recruit participants. I was overwhelmed with the amount of people who took the time to 'like', share, and re-tweet my posts. I felt rushes of adrenaline when high profile tweeters or organisations re-tweeted my post, and I would then

receive a surge of more re-tweets as their many followers did the same. However, what touched me the most was the amount of men who sent a message to say how important they felt the issue of men's mental health was and congratulating me for giving men a voice in this way. I was also incredibly pleased with the amount of men who took the time to complete the survey, as typically men are less likely to participate in online research (Patel, Doku, & Tennakoon, 2003). For me, this has highlighted even further the importance of research within psychology and how there are many groups of people out there wanting to be heard. I feel that social media has been a very useful tool in networking, recruiting, disseminating and discussing research and psychological ideas, and I feel this is something more psychologists could be involved in.

Through conducting my research I have learnt more about the greater need for gender sensitive research. Addis and Mahalik (2003) state that "framing research questions in terms of men versus women typically leads to conclusions of the form, men are more X, and women are more Y" (p. 7), which they can then be used to stereotype and constrain both women and men in the research context. This has helped me to view research in a more gender aware and critical way, as some studies that compare the genders may fail to address within-group or within-person variability. When I was reading papers for my systematic review, I found many studies would group male and female survivors of sexual abuse together in their data

analysis, which meant some gender specific themes such as the fear of being perceived as gay in male survivors may not have been picked up.

3.6 Being a Man and Writing about Men

Throughout the process of writing these three papers I have tried to be mindful about the fact that I am a male and am writing about men's issues, a topic I feel passionate about. I wanted to highlight the importance of these issues for men and think about ways in which clinical psychology can contribute, while at the same time be aware that traditionally men have been the dominant sex in society. Throughout history, women have been neglected, oppressed and subjugated, have had to fight for their rights, and today discrimination against women continues to be present in our society. By focussing on men's issues I was conscious that it could seem as if I was ignoring or downplaying the needs of women in terms of psychology and mental health. On the contrary, I have found that through conducting my thesis research I have become even more aware of the importance of not falling into downplaying or under representing the needs of one gender to make a point about the other.

3.7 Being a Male Clinical Psychologist

It is with great hope and excitement that within the next few months I will be qualifying as a clinical psychologist. Along with the satisfaction of achieving

a very important goal, it marks the end of a chapter of profound personal and professional development, in perhaps more ways than I could possibly comprehend at the present time whilst I am still in the midst of it. I feel extremely fortunate to have had the experiences I have had, which I will carry forward in the rest of my personal and professional life as I continue to grow and develop. Alongside the experience comes the title of “Doctor” and the status and privilege it holds within society. I would like to use this status to continue promoting men’s mental health through my clinical practice and research, as well as being an advocate for issues relevant to people from other minority groups who may feel their voice is not being heard. Later this year the BPS is aiming to hold a vote of its members regarding the creation of a Section for Male Psychology, which will focus on topics such as male suicide, help seeking, male-friendly therapy, and other issues (Barry, 2017). This is something I would certainly like to support.

For me, being a clinical psychologist is more than its individual core competencies. It is a combination of all of them together with being a reflective-practitioner and a scientist-practitioner and how these two roles complement one another. Training has taught me many skills from formulation and consultancy to teaching and researching, and these are things I will continue to work on and develop further, as I feel it is an ongoing process rather than a destination. I believe these skills place clinical psychologists in a unique position within many teams. Being a reflective-practitioner I hope to be able to spot things in my clinical practice

that perhaps are not working or could be changed, and be able to use my scientist-practitioner skills to investigate, with the aim of influencing service improvements that are informed by practice-based evidence as well as evidence-based practice.

3.8 Conclusion

Overall, I have found the process of conceiving, planning, researching and writing my thesis as a worthwhile and important piece of work. It has enabled me to not only reflect on my own gender within the profession but the gender and minority status of the clients I may be working with. It has also helped me to further develop many skills in the actual conducting of and writing research, but also in time management and managing different demands, handling stress, seeking help, taking care of myself, and seeing the importance of being both a research academic and a clinical practitioner. In writing this reflective paper, I feel I have now been able to appreciate this process in a greater way, and it has increased my excitement at the prospect of becoming a qualified clinical psychologist and starting the next chapter in my career.

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Appendices

Appendix A: Sexual Abuse: A Journal of Research and Treatment - Instructions to Authors

Sexual Abuse

A Journal of Research and Treatment

2015 Impact Factor: 1.981

2015 Ranking: 51/122 in Psychology, Clinical | 10/57 in Criminology & Penology

2016 Release of Journal Citation Reports, Source: 2015 Web of Science Data

Official Journal of the Association for the Treatment of Sexual Abusers

Editor

Michael Seto, Ph.D.,

C.Psych.

Royal Ottawa Health Care Group, Brockville,

Ontario, Canada

eISSN: 1573286X | ISSN: 10790632 | Current volume: 29 | Current issue: 3 Frequency: Bi-monthly

Description: *Sexual Abuse: A Journal of Research and Treatment*, the official journal of the Association for the Treatment of Sexual Abusers, provides a forum for the latest original research and scholarly reviews on both clinical and theoretical aspects of sexual abuse.

Unlike other publications that present a mix of articles on sexual abuse and human sexuality in general, *Sexual Abuse* is the only one to focus exclusively on this field, thoroughly investigating its etiology, consequences, prevention, treatment and management strategies.

The in-depth studies provide essential data for those working in both clinical and academic environments, including psychologists, psychiatrists, social workers, and therapists/counselors, as well as corrections officers and allied professionals in children's services.

Aims & Scope: *Sexual Abuse: A Journal of Research and Treatment*, the official journal of the Association for the Treatment of Sexual Abusers, provides an international and multi-disciplinary forum for the latest research (quantitative or qualitative) and scholarly reviews on theoretical, clinical, and policy-relevant aspects of sexual abuse. The journal publishes rigorously peer-reviewed articles on the characteristics, etiology, life course, prevention, assessment, treatment, management, and consequences of individuals who have perpetrated sexual abuse and those who are at risk of doing so. This research provides essential evidence for those working in mental health, criminal justice, public policy, advocacy, and academic settings, including allied professionals working with those who have experienced sexual abuse.

Submission Guidelines: Instructions to Authors

SAJRT uses an online submission and review platform. Manuscripts should be submitted electronically to <http://mc.manuscriptcentral.com/sajrt>. Authors will be required to set up an online account on the SAGE Track system powered by ScholarOne. From their account, a new submission can be initiated. Authors will be asked to provide the required information (author names and contact information, abstract, keywords, etc.), complete submission checklist, and to upload the "title page" and "main document" separately to ensure that the manuscript is ready for blind review. Supplemental materials (e.g., additional tables, figures) can also be uploaded, when applicable, and will need to be prepared for blind review. The site contains links to an online user's guide for help navigating the site.

Manuscripts are subjected to blind peer review and require the author's name(s) and affiliation listed on a separate page. Any other identifiable information, including any references in the manuscript, the notes, the title, supplemental materials, and reference sections, should be removed from the paper and listed on separate pages.

Manuscripts should be prepared according to the guidelines set forth in the Publication Manual of the American Psychological Association (6th ed., 2010). This includes stipulations regarding page layout, manuscript sections and headings, and formatting of references, tables, and figures. DOI numbers when available for listed references are to be included. Effect sizes and confidence intervals are reported, where appropriate.

Each submission should also include an abstract between 100 and 150 words and 4-5 keywords.

Submission of a manuscript implies a commitment by the author to publish in the journal. If the manuscript is accepted, the editors assume that any manuscript submitted to *SAJRT* is not currently under consideration by any other journal.

If you are interested in open access, click [here](#). The standard article processing charge for SAGE Choice is 3,000 USD/1,600 GBP. The fee excludes any other potential author fees levied by some journals (such as color charges) as well as taxes where applicable.

Appendix B: Ethics Certificate for Systematic Review



Certificate of Ethical Approval

Applicant:

Robert O'Flaherty

Project Title:

Barriers to Disclosure for Male Survivors of Sexual Abuse: A Systematic Review

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

03 January 2017

Project Reference Number:

P50278

Appendix C: Quality Assessment Checklist

1	Does the title reflect the content?	
2	Are the authors credible?	
3	Does the abstract summarise the key components?	
4	Is the rationale for undertaking the research clearly outlined?	
5	Is the literature review comprehensive and up to date?	
6	Is the aim of the research clearly stated?	
7	Are all ethical issues identified and addressed?	
8	8 Is the methodology identified and justified?	
	Quantitative	Qualitative
9	Is the study design clearly identified, and is the rationale for the choice of design evident?	Are the philosophical background and study design identified and the rationale for choice of design evident?
10	Is there an experimental hypothesis clearly stated? Are the key variables clearly defined?	Are the major concepts identified?
11	Is the population identified?	Is the context of the study outlined?
12	Is the sample adequately described and reflective of the population?	Is the selection of participants described and the sampling method identified?
13	Is the method of data collection valid and reliable?	Is the method of data collection auditable?
14	Is the method of data analysis valid and reliable?	Is the method of data analysis credible and confirmable
15	Are the results presented in a way that is appropriate and clear?	
16	Are the results generalizable?	Are the results transferable?
17	Is the discussion comprehensive?	
18	Is the conclusion comprehensive?	

Appendix D: The Journal of Men's Studies - Instructions to Authors

The Journal of Men's Studies

An Official Journal of the American Men's Studies Association

A Scholarly Journal About Men and Masculinities

Editor-in-Chief

James Doyle, PhD Roane State Community College

eISSN: 19330251 | ISSN: 10608265 | Current volume: 25 | Current issue: 1 Frequency: 3 Times/Year

Description: *The Journal of Men's Studies* publishes the best research—both theoretical and empirical—in the emergent men's studies field, recognizing the varied influences of class, culture, race, and sexual orientation on defining men's experiences. The journal's cross-disciplinary and cross-cultural character disseminates material by men's studies scholars from various perspectives (political, social, cultural, and historical) as well as various disciplines (anthropology, sociology, history, psychology, literature, theology).

Along with regular articles (approximately 6,000 to 8,000 words), *The Journal of Men's Studies* routinely publishes book reviews (approximately 750 words).

Aims & Scope: *The Journal of Men's Studies* is a scholarly, peer-reviewed journal devoted to providing an interdisciplinary forum for the critical discussion of issues involving men and masculinities and for disseminating new knowledge about men's lives to a broad audience that includes scholars, practitioners, researchers, policy makers, and students.

Submission Guidelines: Submissions must be sent electronically to <https://mc.manuscriptcentral.com/men>.

Manuscript preparation.

The Journal of Men's Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (6th ed., 2009). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References. Basic formats are as follows:

Journal article:

Chua, P., & Fujino, D. C. (1999). Negotiating new Asian-American masculinities: Attitudes and gender expectations. *The Journal of Men's Studies*, 7, 391-413.

Article in an Internet-only journal:

Gordon, R. (2004, June 15). The men among us. *Library Journal.com*. Retrieved October 15, 2006, from <http://www.libraryjournal.com/article/CA423789.html>

Book:

Lee, T. (2007). *A new path at midlife: Transformative relationship & story for men*. Harriman, TN: Men's Studies Press.

Chapter in a book:

Pleck, J. H. (1995). The gender role strain paradigm: An update. In R. F. Levant & W. S. Pollack (Eds.), *A new psychology of men* (pp. 11-32). New York: Basic Books.

Dissertation:

Davis, F. (1987). *Antecedents and consequents of gender role conflict: An empirical test of sex role strain analysis* (Doctoral dissertation, Ohio State University, 1987). *Dissertation Abstracts International*, 48(11), 3443.

Figures.

Graphic files are accepted if supplied as Tiff files (.tiff). High-quality printouts are needed for all figures. The minimum line weight for line art is 0.5 point for optimal printing.

Review Procedure.

The *Journal of Men's Studies* uses a masked review process. Authors are asked to include all identifying information in the cover letter, including the manuscript title, the authors' names, institutional affiliations, and e-mail addresses. The first page of the manuscript should include only the article's title, abstract, and keywords. Footnotes containing information that would reveal the authors' identity and/or affiliation should be removed. Every effort should be made to see that the manuscript itself contains no clues to the author's identity.

Permissions.

When an article has been accepted, authors are required to obtain and provide to the editor all necessary permissions to reproduce in print and electronic form any copyrighted work, including, for example, photographs of people.

Publication Policy.

Our policy prohibits an author from submitting the same manuscript for concurrent consideration by two or more publications. Our policy also prohibits publication of a manuscript that has already been published in whole or substantial part elsewhere. Authors of manuscripts describing research using human participants are required to comply with APA ethical standards in the treatment of human participants. Upon acceptance of a manuscript, authors must sign and return a copyright agreement.

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If you or your funder wish your article to be freely available online to nonsubscribers immediately upon publication (gold open access), you can opt for it to be included in SAGE Choice, subject to payment of a publication fee. The manuscript submission and peer review procedure is unchanged. On acceptance of your article, you will be asked to let SAGE know directly if you are choosing SAGE Choice. To check journal eligibility and the publication fee, please visit [SAGE Choice](#). For more information on open access options and compliance at SAGE, including self author archiving deposits (green open access) visit [SAGE Publishing Policies](#) on our Journal Author Gateway.

Appendix E: Ethics Certificate for Empirical Study



Certificate of Ethical Approval

Applicant:

Robert O'Flaherty

Project Title:

What factors influence men's help-seeking intention for psychological problems?

This is to certify that the above named applicant has completed the Coventry University Ethical Approval process and their project has been confirmed and approved as Medium Risk

Date of approval:

15 June 2016

Project Reference Number:

P37770

Appendix F: Full Online Survey

(Please note that the options for each question were displayed in a drop down menu online and are being displayed under the main questions here for illustrative purposes only)



Page 1: Participant Information

Research Study on men's views of healthcare services

Research Study on men's views of healthcare services

Lead researcher: Robert O'Flaherty (Trainee Clinical Psychologist at the Universities of Coventry & Warwick) oflaherr@uni.coventry.ac.uk 024 7688 8328

Supervised by: Dr Anthony Colombo and Dr Tom Patterson

Please read the following carefully before continuing:

What is the purpose of this study?

The purpose of this study is to investigate men's views of healthcare services.

Why have I been invited to take part?

We are looking for British men aged between 18 and 65 years of age to take part in this study.

Do I have to take part?

No. Taking part in this study is completely optional. If you decide to take part then you are free to stop the study at any time and are not obliged to submit the survey. You can save your answers and come back to them before completing the survey if you wish.

What is involved in taking part?

The study will involve completing a questionnaire about your views and should take around 15 minutes to complete. You will be presented with a series of questions and you will be asked to select your response from the options provided, for example, by stating how much you agree or disagree with a given statement. You will also be asked to read 7 short stories (about 4 lines each) and asked some short questions based on each scenario.

Your responses will be anonymous. You will not be required to give any identifiable information. However, you will be offered the chance to give your email address to receive an information sheet once the results have been analysed if you wish. In this case, your email address will be kept confidential, with only the lead researcher having access to it and using it solely to inform you of the results. Once we have sent you a summary of the findings, your e-mail will be deleted from our database.

What are the benefits of taking part?

By taking part in this survey you will be contributing to the scientific understanding of the area of men's views on health care.

What are the potential disadvantages of taking part?

Occasionally participants may find some of the questions make them think about their own healthcare needs. It is not anticipated that this will cause any distress. However, if answering these questions does leave you feeling upset or distressed we would suggest you contact your GP for support. Other sources of support include the organisations Mind (0300 123 3393) and the Samaritans (116 123). These numbers along with details of other support organisations will be listed again at the end of this survey.

What will happen with the results of the study?

It is anticipated that the results will be used to help services understand the healthcare needs of men better. The findings will be communicated to a range of audiences through publications and reports.

Who has reviewed this study?

Coventry University's ethics committee have reviewed and approved this study (Ref: P37770).

Questions or Concerns

If you have any questions, queries or concerns regarding this research please contact the lead researcher, Robert O'Flaherty at oflaherr@uni.coventry.ac.uk

Page 2: Consent Form

Please select 'yes' in each box if you agree with the statement next to it.

1. I have read and understood the information about this study that has been provided. Required

☐ Yes

2. I have had the opportunity to consider the information and realise if I have any questions regarding the research I can email the lead researcher at oflaherr@uni.coventry.ac.uk Required

☐ Yes

3. I understand that my participation is completely voluntary. I am aware that I have the right to stop the questionnaire at any point and not submit my answers. Required

☐ Yes

4. I understand that my responses will be kept anonymous and that I cannot be identified from the information I have provided. However, if I give my email address to find out more regarding the study's results that this will be kept confidential. Required

☐ Yes

5. I understand that the data collected will be retained for 5 years before being destroyed, in keeping with the universities' policies. Required

☐ Yes

6. I understand that at any point I may contact the lead researcher Robert O'Flaherty at oflaherr@uni.coventry.ac.uk if I would like more information about the study. Required

☐ Yes

7. I agree to take part in the above study. Required

☐ Yes

Page 3: Scenario 1 of 7

1. In the past two weeks **Jake** has found it hard to chill out or relax. He's also been feeling pretty overwhelmed, "twitchy" and intolerant. He's been over-reacting to things that are going on.

If you were feeling like Jake, how likely is it that you would seek help from the following people?

Please indicate your response by choosing the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

8. a. Intimate partner (e.g. girlfriend, boyfriend, husband, wife) Required

9. b. Friend (not related to you) Required

10. c. Parent Required

11. d. Other relative/family member Required

12. e. Mental health professional (e.g. psychologist, social worker, counsellor) Required

13. f. Phone helpline (e.g. Lifeline) Required

14. g. Doctor/GP Required

15. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	Required
16. i. I would seek help from someone	Required
17. j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank)	
17.a. Please specify:	
18. k. What, if anything, is wrong with Jake?	Required
19. Do you think Jake needs help?	Required
<input type="radio"/> Yes	
<input type="radio"/> No	

Page 4: Scenario 2 of 7

2. In the past two weeks **James** has noticed that he has felt worried or scared without any particular reason, and his hands have trembled a lot even though he doesn't drink coffee or caffeine drinks. On a few occasions he has felt close to panic, and at the same time become aware that his mouth has got really dry and that he has difficulty breathing.

If you were feeling like James, how likely is it that you would seek help from the following people?

Please indicate your response by choosing the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

20. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife) Required

21. b. Friend (not related to you)	Required
22. c. Parent	Required
23. d. Other relative/family member	Required
24. e. Mental health professional (e.g. psychologist, social worker, counsellor)	Required
25. f. Phone helpline (e.g. Lifeline)	Required
26. g. Doctor/GP	Required
27. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain)	Required
28. i. I would seek help from someone	Required
29. j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank)	
29.a. Please specify:	Optional
30. k. What, if anything, is wrong with James?	Required
31. l. Do you think James needs help?	Required
<input type="radio"/> Yes	
<input type="radio"/> No	

Page 5: Scenario 3 of 7

3. **John** has been feeling unusually sad and down-hearted for most of the day for nearly two weeks. He doesn't feel like eating and has lost weight. He can't keep his mind on his studies and his marks have dropped. He has put off making decisions and feels that even day-to-day tasks are too much

for him. To him, life feels meaningless and he doesn't feel he is worth much as a person.

If you were feeling like John, how likely is it that you would seek help from the following people?

Please indicate your response by choosing the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

32. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife) Required

33. b. Friend (not related to you) Required

34. c. Parent Required

35. d. Other relative/family member Required

36. e. Mental health professional (e.g. psychologist, social worker, counsellor) Required

37. f. Phone helpline (e.g. Lifeline) Required

38. g. Doctor/GP Required

39. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain) Required

40. i. I would seek help from someone Required

41. j. I would seek help from another not listed above (please list in the space provided, e.g., work colleague. If no, leave blank)

41.a. Please specify:

42. k. What, if anything, is wrong with John? Required

43. l. Do you think John needs help? Required

☐ Yes

☐ No

Page 6: Scenario 4 of 7

4. In the last four weeks **Josh** has found himself thinking about how easy it would be to end it all, and he knows that at least once a week during this time he has thought about how and when he could kill himself.

If you were having thoughts like Josh, how likely is it that you would seek help from the following people?

Please indicate your response by choosing the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

44. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife) Required

45. b. Friend (not related to you) Required

46. c. Parent Required

47. d. Other relative/family member Required

48. e. Mental health professional (e.g. psychologist, social worker, counsellor) Required	
49. f. Phone helpline (e.g. Lifeline) Required	
50. g. Doctor/GP Required	
51. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain) Required	
52. i. I would seek help from someone Required	
53. j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)	
53.a. Please specify:	
54. k. What, if anything, is wrong with Josh? Required	
55. l. Do you think Josh needs help? Required	
<input type="radio"/> Yes	
<input type="radio"/> No	

Page 7: Scenario 5 of 7

5. In the last couple of months **Jack** has found himself doing things when he is drinking alcohol that he later regrets and which he's been getting into trouble for. He knows he's needing more and more to feel the same way after drinking and to complete his daily tasks. When he's not drinking, he's been feeling more and more wound up, sad and confused. He's falling behind in his uni work.

If you were relying on a substance like Jack, how likely is it that you would seek help from the following people?

Please indicate your response by choosing the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

56. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife) Required

57. b. Friend (not related to you) Required

58. c. Parent Required

59. d. Other relative/family member Required

60. e. Mental health professional (e.g. psychologist, counsellor, D&A worker) Required

61. f. Phone helpline (e.g. Lifeline) Required

62. g. Doctor/GP Required

63. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain) Required

64. i. I would seek help from someone Required

65. j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)

65.a. Please specify:

66. k. What, if anything, is wrong with Jack? Required

67. l. Do you think Jack needs help? Required

☐ Yes

☐ No

Page 8: Scenario 6 of 7

6. **Jeff** is living at home with his parents. Recently he's stopped attending his classes at uni and over the past 6 months he has stopped seeing his friends. He's also started locking himself in his bedroom and refusing to eat with the family or have a bath. His parents hear him walking around his room at night and even though he is alone, they hear him shouting and arguing as though someone is there. He feels afraid to leave the house because he believes he's being spied on by the neighbour.

If you were feeling like Jeff, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

68.68. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife)
Required

69. b. Friend (not related to you) Required

70. c. Parent Required

71. d. Other relative/family member Required

72. e. Mental health professional (e.g. psychologist, social worker, counsellor) Required

73. f. Phone helpline (e.g. Lifeline) Required

74. g. Doctor/GP Required

75. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain) Required

76. i. I would seek help from someone Required

77. j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)

77.a. Please specify:

78. k. What, if anything, is wrong with Jeff? Required

79. l. Do you think Jeff needs help? Required

☐ Yes

☐ No

Page 9: Scenario 7 of 7

7. In the last couple of weeks **Jacob** has felt crushing pressure in the left side of his chest, and had pain in his left jaw, left arm, back and stomach. Jacob has also felt short of breath and light headed, and on several occasions, Jacob thought he was going to be sick.

If you were feeling like Jacob, how likely is it that you would seek help from the following people?

Please indicate your response by putting a line through the number that best describes your intention to seek help from each help source that is listed.

1 = Extremely Unlikely

2 = Unlikely

3 = Possibly unlikely

4 = Likely possibly

5 = Likely

6 = Extremely Likely

80. a. Intimate partner (e.g., girlfriend, boyfriend, husband, wife) Required

81. b. Friend (not related to you) Required

82. c. Parent Required

83. d. Other relative/family member Required

84. e. Mental health professional (e.g. psychologist, social worker, counsellor) Required

85. f. Phone helpline (e.g. Lifeline) Required

86. g. Doctor/GP Required

87. h. Minister or religious leader (e.g. Priest, Rabbi, Chaplain) Required

88. i. I would seek help from someone Required

89. j. I would seek help from another not listed above (please list in the space provided, (e.g., work colleague. If no, leave blank)

89.a. Please specify:

90. k. What, if anything, is wrong with Jacob? Required

91. l. Do you think Jacob needs help? Required

☐ Yes

☐ No

- 1-Strongly agree
- 2-Agree
- 3-Agree slightly
- 4-Slightly disagree
- 5-Disagree
- 6-Strongly disagree

92. 1. Most people would willingly accept someone who has experienced mental health difficulties as a close friend Required

93. 2. Most people believe that a person who has been in a mental health hospital is just as intelligent as the average person Required

94. 3. Most people believe that a former mental health patient is just as trustworthy as the average citizen Required

95. 4. Most people would accept a fully recovered former mental health patient as a teacher of young children in a public school Required

96. 5. Most people feel that entering a mental health hospital is a sign of personal failure Required

97. 6. Most people would not hire a former mental health patient to take care of their children, even if he or she had been well for some time Required

98. 7. Most people think less of a person who has been in a mental health hospital Required

99. 8. Most employers will hire a former mental health patient if he or she is qualified for the job Required

100. 9. Most employers will pass over the application of a former mental health patient in favour of another applicant Required

101. 10. Most people in my community would treat a former mental health patient just as they would treat anyone Required

102. 11. Most young people would be reluctant to date someone who has been hospitalised for a serious mental health disorder Required

103. 12. Once they know a person was in a mental health hospital, most people will take his or her opinions less seriously Required

Page 11: Questionnaire 2 of 2

1	-		Disagree
2	-	Partly	disagree
3	-	Partly	agree
4	-	Agree	

104. 1. If I believed I was having a mental breakdown, my first inclination would be to get professional attention Required

105. 2. The idea of talking about problems with a psychologist strikes me as a poor way to get rid of emotional conflicts Required

106. 3. If I were experiencing a serious emotional crisis at this point in my life, I would be confident that I could find relief in psychotherapy Required

107. 4. There is something admirable in the attitude of a person who is willing to cope with his or her conflicts and fears without resorting to professional help Required

108. 5. I would want to get psychological help if I were worried or upset for a long period of time Required

109. 6. I might want to have psychological counseling in the future Required

110. 7. A person with an emotional problem is not likely to solve it alone; he or she is likely to solve it with professional help Required

111. 8. Considering the time and expense involved in psychotherapy, it would have doubtful value for a person like me Required

112. 9. A person should work out his or her own problems; getting psychological counseling would be a last resort Required

113. 10. Personal and emotional troubles, like many things, tend to work out by themselves Required

Page 12: About You

Finally, please answer the following questions about you and your background:

114. How old are you? (age in years) Required

Please enter a whole number (integer).

Your answer should be no more than 2 characters long.

115. What is your sex? Required

☐

Male

☐

Female

116. What ethnic group do you belong to? Required

☐

White - British

☐

White - Irish

☐

White - Other White

☐

Mixed - White and Black Caribbean

☐

Mixed - White and Black African

☐

Mixed - White and Asian

☐

Mixed - Other Mixed

☐

Asian or Asian British - Indian

☐

Asian or Asian British - Pakistani

☐

Asian or Asian British - Bangladeshi

☐

Asian or Asian British - Other Asian

☐

Black or Black British - Caribbean

- ☐ Black or Black British - African
- ☐ Black or Black British - Other Black
- ☐ Chinese or other ethnic group - Chinese
- ☐ Chinese or other ethnic group - Other ethnic group (please specify)

116.a. If you selected Other, please specify:

117. How do you define your sexuality? Required

- ☐ Heterosexual
- ☐ Bisexual
- ☐ Gay

118. What is the highest level of education you have had? Required

- ☐ GCSEs
- ☐ NVQs
- ☐ A Levels
- ☐ Undergraduate Degree
- ☐ Master's Degree
- ☐ Doctorate

119. If you would like to receive information about this study once the results have been analysed please enter your email address here.

Please enter a valid email address.

Page 13: Thank You

Thank you for participating in this survey. As mentioned at the start of the survey your answers will remain anonymous. You have helped to contribute to a psychological study looking at different factors which may affect men's willingness to seek help for psychological difficulties. These factors include attitudes towards seeking help and perceived stigma.

If, by completing this study, you think you would like to seek some support for yourself we would recommend the organisations below:

- Your GP, who can refer you onto the most appropriate service for you in your area

- Mind - 0300 123 3393 - <http://www.mind.org.uk/>
- The Samaritans - 116 123 - <http://www.samaritans.org/>
- Campaign Against Living Miserably (CALM) - 0800 58 58 58 - <https://thecalmzone.net>

If you would like more information about male mental health, we would recommend the following:

- <https://www.menshealthforum.org.uk/>
- <https://uk.movember.com/mens-health/mental-health>
- <http://www.combatstress.org.uk/>
- <http://menssheds.org.uk/>
- <https://www.survivorsuk.org/>

Please contact the lead researcher Robert O'Flaherty at oflaherr@uni.coventry.ac.uk if you have any questions regarding this study.

Thank you again for your participation.

Appendix G: Data Analysis Assumptions

For questions 1-3 the data was checked that it satisfies a series of assumptions. It was concluded that the DV for each question is continuous and in each case the IV is categorical. There were no outliers in the range of scores on the DV. According to the Shapiro Wilk test, the data was not normally distributed, ($p \leq .005$ across all conditions for aims 1-3) showing a slight positive skewness. Finally, the data failed the Mauchly's test of sphericity:

- Aim 1: ($X^2(20) = 237.135, p \leq .001$)
- Aim 2: ($X^2(27) = 172.863, p \leq .001$)

Aim 3 (for each condition):

- Stress: ($X^2(27) = 224.167, p \leq .001$)
- Anxiety: ($X^2(27) = 133.351, p \leq .001$)
- Depression: ($X^2(27) = 141.952, p \leq .001$)
- Suicidal: ($X^2(27) = 206.929, p \leq .001$)
- Alcohol Problems: ($X^2(27) = 138.576, p \leq .001$)
- Psychosis: ($X^2(27) = 213.838, p \leq .001$)
- Heart Problems: ($X^2(27) = 287.026, p \leq .001$)

Mauchly's test of sphericity looks to see if the variances of the differences between all combinations of related groups are equal. Violating the test of sphericity can lead to an increase in the Type 1 error rate (i.e. detecting a statistically significant result when there is not one).

Multivariate tests were conducted as these do not require the data to satisfy for assumption of sphericity.

For aims 1-3 the Wilks' Lambda was significant

- Aim 1: $F_{(6, 230.000)} = 37.593, p \leq .0001$, Wilks' $\Lambda = .505$, partial $\eta^2 = .495$
- Aim 2: $F_{(7, 229.000)} = 117.243, p \leq .0001$, Wilks' $\Lambda = .218$, partial $\eta^2 = .782$

Aim 3 (for each condition):

- Stress: $F_{(7, 229.000)} = 83.811, p \leq .0001$, Wilks' $\Lambda = .281$, partial $\eta^2 = .719$
- Anxiety: $F_{(7, 229.000)} = 92.454, p \leq .0001$, Wilks' $\Lambda = .261$, partial $\eta^2 = .739$
- Depression: $F_{(7, 229.000)} = 72.655, p \leq .0001$, Wilks' $\Lambda = .310$, partial $\eta^2 = .690$
- Suicidal Thoughts: $F_{(7, 229.000)} = 47.269, p \leq .0001$, Wilks' $\Lambda = .409$, partial $\eta^2 = .591$
- Alcohol Problems: $F_{(7, 229.000)} = 53.176, p \leq .0001$, Wilks' $\Lambda = .381$, partial $\eta^2 = .619$
- Psychosis: $F_{(7, 229.000)} = 43.233, p \leq .0001$, Wilks' $\Lambda = .431$, partial $\eta^2 = .569$

- Heart Attack: $F_{(7, 229.000)} = 259.856, p \leq .0001, \text{Wilks' } \Lambda = .112, \text{partial } \eta^2 = .888$

To reinforce this data Tests of With-Subjects Effects was also used. When using a repeated measures ANOVA with a Greenhouse-Geisser correction, the mean scores for all aims were statistically significantly different

- Aim 1: $F_{(4.565, 1072.835)} = 35.629, p \leq .0001, \text{Partial } \eta^2 = .132$
- Aim 2: $F_{(5.720, 1344.166)} = 35.629, p \leq .0001, \text{Partial } \eta^2 = .429$

Aim 3 (for each condition):

- Stress: $F_{(5.429, 1275.752)} = 120.277, p \leq .0001, \text{Partial } \eta^2 = .339$
- Anxiety: $F_{(5.990, 1407.610)} = 133.885, p \leq .0001, \text{Partial } \eta^2 = .363$
- Depression: $F_{(5.900, 1386.453)} = 110.906, p \leq .0001, \text{Partial } \eta^2 = .321$
- Suicidal Thoughts: $F_{(5.498, 1291.926)} = 75.720, p \leq .0001, \text{Partial } \eta^2 = .244$
- Alcohol Problems: $F_{(5.897, 1385.817)} = 74.173, p \leq .0001, \text{Partial } \eta^2 = .240$
- Psychosis: $F_{(5.519, 1296.850)} = 73.217, p \leq .0001, \text{Partial } \eta^2 = .238$
- Heart Attack: $F_{(5.215, 1225.529)} = 259.873, p \leq .0001, \text{Partial } \eta^2 = .525$

This shows that men differ in their intentions to seek help depending on the mental health difficulty they experience, that help-seeking intentions differ across help-seeking source, irrespective of the mental health difficulty experienced. The results also suggest that the effect size is very large across the three aims (Cohen, 1988).

Assumptions Used in Data Analysis for Aim 8

Firstly, multicollinearity was checked to determine whether any of the variables used in the regression correlate too well together. The coefficients are total behaviour beliefs scores: .252, total stigma score: -.043, and total control beliefs: .754. Visually, there appears to be no correlations between IVS, which suggests there is no interaction effect and they are independent factors. To statistically check for multicollinearity the collinearity statistics of tolerance and VIF were checked. A tolerance below 0.2 indicates a potential problem and below 0.1 a serious problem. If the largest VIF is greater than 10 then there is also cause for concern. Similarly, if the average VIF is substantially greater than 1 it could indicate bias in the regression. However, the VIF scores were all in the 0.9 region, and the tolerance scores were in the 1.0 region. This shows there are no concerns regarding collinearity.

In terms of normality and homoscedasticity the residuals scatter plots and normal probability plots were examined (see appendix H). In plots suggest a normal

distribution of data as the data roughly falls in a straight diagonal line, from bottom left. In the scatter plots a few outliers can be seen, but generally data fall within the expected area.

Appendix H: SPSS Output for Aims 1-9

Aim 1

Table 8: Multivariate tests^a for aim 1 – for which form of mental health problem are men most likely to seek help?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
MentalHealthCondi- tions	Pillai's Trace	.495	37.593 ^b	6.000	230.000	.000	.495
	Wilks' Lambda	.505	37.593 ^b	6.000	230.000	.000	.495
	Hotelling's Trace	.981	37.593 ^b	6.000	230.000	.000	.495
	Roy's Largest Root	.981	37.593 ^b	6.000	230.000	.000	.495

a. Design: Intercept

Within Subjects Design: MentalHealthConditions

b. Exact statistic

Table 9: Tests of within-subjects effects for aim 1 – for which form of mental health problem are men most likely to seek help?

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
MentalHealthCon ditions	Sphericity Assumed	5126.927	6	854.488	35.629	.000	.132
	Greenhouse- Geisser	5126.927	4.565	1123.032	35.629	.000	.132
	Huynh-Feldt	5126.927	4.667	1098.588	35.629	.000	.132
	Lower-bound	5126.927	1.000	5126.927	35.629	.000	.132
Error(MentalHealt hConditions)	Sphericity Assumed	33815.644	1410	23.983			
	Greenhouse- Geisser	33815.644	1072.8 35	31.520			
	Huynh-Feldt	33815.644	1096.7 06	30.834			
	Lower-bound	33815.644	235.00 0	143.896			

Aim 2

Table 10: Multivariate tests^a for aim 2 – for mental health problems in general, which form of help-seeking source are men most likely to turn to for support?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.782	117.243 b	7.000	229.000	.000	.782
	Wilks' Lambda	.218	117.243 b	7.000	229.000	.000	.782
	Hotelling's Trace	3.584	117.243 b	7.000	229.000	.000	.782
	Roy's Largest Root	3.584	117.243 b	7.000	229.000	.000	.782

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 11: Tests of within-subjects effects for aim 2 – for mental health problems in general, which form of help-seeking source are men most likely to turn to for support?

Source		Type III Sum of Squares	df	Mean Square	F	Sig.	Partial Eta Squared
HelpSources	Sphericity Assumed	54455.956	7	7779.422	176.35 4	.000	.429
	Greenhouse- Geisser	54455.956	5.720	9520.514	176.35 4	.000	.429
	Huynh-Feldt	54455.956	5.879	9263.152	176.35 4	.000	.429
	Lower-bound	54455.956	1.000	54455.95 6	176.35 4	.000	.429
Error(HelpSources)	Sphericity Assumed	72565.294	1645	44.113			
	Greenhouse- Geisser	72565.294	1344.1 66	53.985			
	Huynh-Feldt	72565.294	1381.5 11	52.526			
	Lower-bound	72565.294	235.00 0	308.788			

Aim 3

Table 12: Multivariate tests^a for aim 3, stress condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSources	Pillai's Trace	.719	83.811 ^b	7.000	229.000	.000	.719
	Wilks' Lambda	.281	83.811 ^b	7.000	229.000	.000	.719
	Hotelling's Trace	2.562	83.811 ^b	7.000	229.000	.000	.719
	Roy's Largest Root	2.562	83.811 ^b	7.000	229.000	.000	.719

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 13: Multivariate tests^a for aim 3, anxiety condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.739	92.454 ^b	7.000	229.000	.000	.739
	Wilks' Lambda	.261	92.454 ^b	7.000	229.000	.000	.739
	Hotelling's Trace	2.826	92.454 ^b	7.000	229.000	.000	.739
	Roy's Largest Root	2.826	92.454 ^b	7.000	229.000	.000	.739

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 14: Multivariate tests^a for aim 3, depression condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.690	72.655 ^b	7.000	229.000	.000	.690
	Wilks' Lambda	.310	72.655 ^b	7.000	229.000	.000	.690
	Hotelling's Trace	2.221	72.655 ^b	7.000	229.000	.000	.690
	Roy's Largest Root	2.221	72.655 ^b	7.000	229.000	.000	.690

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 15: Multivariate tests^a for aim 3, suicidal condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.591	47.269 ^b	7.000	229.000	.000	.591
	Wilks' Lambda	.409	47.269 ^b	7.000	229.000	.000	.591
	Hotelling's Trace	1.445	47.269 ^b	7.000	229.000	.000	.591
	Roy's Largest Root	1.445	47.269 ^b	7.000	229.000	.000	.591

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 16: Multivariate tests^a for aim 3, alcohol problems condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.619	53.176 ^b	7.000	229.000	.000	.619
	Wilks' Lambda	.381	53.176 ^b	7.000	229.000	.000	.619
	Hotelling's Trace	1.625	53.176 ^b	7.000	229.000	.000	.619
	Roy's Largest Root	1.625	53.176 ^b	7.000	229.000	.000	.619

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 17: Multivariate tests^a for aim 3, psychosis condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.569	43.233 ^b	7.000	229.000	.000	.569
	Wilks' Lambda	.431	43.233 ^b	7.000	229.000	.000	.569
	Hotelling's Trace	1.322	43.233 ^b	7.000	229.000	.000	.569
	Roy's Largest Root	1.322	43.233 ^b	7.000	229.000	.000	.569

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Table 18: Multivariate tests^a for aim 3, heart attack condition – which is the most popular help source for particular mental health problems for men?

Effect		Value	F	Hypothesis df	Error df	Sig.	Partial Eta Squared
HelpSource s	Pillai's Trace	.888	259.586 _b	7.000	229.000	.000	.888
	Wilks' Lambda	.112	259.586 _b	7.000	229.000	.000	.888
	Hotelling's Trace	7.935	259.586 _b	7.000	229.000	.000	.888
	Roy's Largest Root	7.935	259.586 _b	7.000	229.000	.000	.888

a. Design: Intercept

Within Subjects Design: HelpSources

b. Exact statistic

Aim 4

Table 19: ANOVA data for aim 4 – in terms of men's behavioural beliefs, do they view seeking help from professionals for psychological problems as a worthwhile action to take? Are these beliefs held across different age groups?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	75.591	3	25.197	2.729	.045
Within Groups	2141.969	232	9.233		
Total	2217.559	235			

Table 20: Multiple comparisons across age groups for aim 4 – in terms of men's behavioural beliefs, do they view seeking help from professionals for psychological problems as a worthwhile action to take? Are these beliefs held across different age groups?

(I) Four Age Groups	(J) Four Age Groups	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1.00	2.00	1.48130	.57994	.055	-.0194	2.9820
	3.00	.93888	.60358	.406	-.6230	2.5008
	4.00	.32979	.57638	.940	-1.1617	1.8213
2.00	1.00	-1.48130	.57994	.055	-2.9820	.0194
	3.00	-.54242	.55476	.762	-1.9780	.8931
	4.00	-1.15152	.52504	.128	-2.5102	.2071
3.00	1.00	-.93888	.60358	.406	-2.5008	.6230
	2.00	.54242	.55476	.762	-.8931	1.9780
	4.00	-.60909	.55104	.687	-2.0350	.8168
4.00	1.00	-.32979	.57638	.940	-1.8213	1.1617
	2.00	1.15152	.52504	.128	-.2071	2.5102
	3.00	.60909	.55104	.687	-.8168	2.0350

Aim 5

Table 21: ANOVA data for aim 5 – in terms of men's normative beliefs, do they tend to stigmatise psychological problems? Are these beliefs held across different age groups?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	68.619	3	22.873	1.139	.334
Within Groups	4659.156	232	20.083		
Total	4727.775	235			

Table 22: Multiple comparisons across age groups for aim 5 – in terms of men’s normative beliefs, do they tend to stigmatise psychological problems? Are these beliefs held across different age groups?

(I) Four Age Groups	(J) Four Age Groups	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1.00	2.00	-1.57253	.85532	.258	-3.7859	.6408
	3.00	-.84526	.89018	.778	-3.1488	1.4583
	4.00	-.78911	.85007	.790	-2.9889	1.4107
2.00	1.00	1.57253	.85532	.258	-.6408	3.7859
	3.00	.72727	.81818	.811	-1.3900	2.8445
	4.00	.78342	.77435	.743	-1.2204	2.7872
3.00	1.00	.84526	.89018	.778	-1.4583	3.1488
	2.00	-.72727	.81818	.811	-2.8445	1.3900
	4.00	.05615	.81269	1.000	-2.0469	2.1592
4.00	1.00	.78911	.85007	.790	-1.4107	2.9889
	2.00	-.78342	.77435	.743	-2.7872	1.2204
	3.00	-.05615	.81269	1.000	-2.1592	2.0469

Aim 6

Table 23: ANOVA data for aim 6 – in terms of men’s control beliefs, do they tend to emphasise a degree of perceived self-efficacy about the intention to seek help? Are these beliefs held across different age groups?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	129.287	3	43.096	.603	.614
Within Groups	16582.815	232	71.478		
Total	16712.102	235			

Table 24: Multiple comparisons across age groups for aim 6 – in terms of men’s control beliefs, do they tend to emphasise a degree of perceived self-efficacy about the intention to seek help? Are these beliefs held across different age groups?

(I) Age Groups	(J) Age Groups	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1.00	2.00	.05964	1.61363	1.000	-4.1160	4.2353
	3.00	-.46460	1.67940	.993	-4.8105	3.8813
	4.00	1.44556	1.60373	.804	-2.7045	5.5956
2.00	1.00	-.05964	1.61363	1.000	-4.2353	4.1160
	3.00	-.52424	1.54356	.986	-4.5186	3.4701
	4.00	1.38592	1.46087	.779	-2.3944	5.1663
3.00	1.00	.46460	1.67940	.993	-3.8813	4.8105
	2.00	.52424	1.54356	.986	-3.4701	4.5186
	4.00	1.91016	1.53321	.598	-2.0574	5.8777
4.00	1.00	-1.44556	1.60373	.804	-5.5956	2.7045
	2.00	-1.38592	1.46087	.779	-5.1663	2.3944
	3.00	-1.91016	1.53321	.598	-5.8777	2.0574

Aim 7

Table 25: ANOVA data for aim 7 – in terms of men’s MHL, do they tend to emphasise a degree of accurate knowledge about mental health problems? Are these beliefs held across different age groups?

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	7.981	3	2.660	.456	.713
Within Groups	1352.845	232	5.831		
Total	1360.826	235			

Table 26: Multiple comparisons across age groups for aim 7 – in terms of men’s MHL, do they tend to emphasise a degree of accurate knowledge about mental health problems? Are these beliefs held across different age groups?

(I) Age Groups 4	(J) Age Groups 4	Mean Difference (I- J)	Std. Error	Sig.	95% Confidence Interval	
					Lower Bound	Upper Bound
1.00	2.00	.03578	.46089	1.000	-1.1569	1.2285
	3.00	-.08240	.47968	.998	-1.3237	1.1589
	4.00	.38204	.45806	.838	-.8033	1.5674
2.00	1.00	-.03578	.46089	1.000	-1.2285	1.1569
	3.00	-.11818	.44088	.993	-1.2591	1.0227
	4.00	.34626	.41726	.840	-.7335	1.4260
3.00	1.00	.08240	.47968	.998	-1.1589	1.3237
	2.00	.11818	.44088	.993	-1.0227	1.2591
	4.00	.46444	.43792	.714	-.6688	1.5977
4.00	1.00	-.38204	.45806	.838	-1.5674	.8033
	2.00	-.34626	.41726	.840	-1.4260	.7335
	3.00	-.46444	.43792	.714	-1.5977	.6688

Aim 8&9

Table 27: Correlation scores for aims 8&9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

		TotalHSmhp	TotalBBscore	TotalNBstigma	TotalCBhelp	TotalMHL
Pearson Correlation	TotalHSmhp	1.000	.264	-.030	.644	.066
	TotalBBscore	.264	1.000	-.108	.206	.055
	TotalNBstigma	-.030	-.108	1.000	.037	-.033
	TotalCBhelp	.644	.206	.037	1.000	.108
	TotalMHL	.066	.055	-.033	.108	1.000
Sig. (1-tailed)	TotalHSmhp	.	.000	.323	.000	.157
	TotalBBscore	.000	.	.049	.001	.199
	TotalNBstigma	.323	.049	.	.285	.309
	TotalCBhelp	.000	.001	.285	.	.048
	TotalMHL	.157	.199	.309	.048	.
N	TotalHSmhp	236	236	236	236	236
	TotalBBscore	236	236	236	236	236
	TotalNBstigma	236	236	236	236	236
	TotalCBhelp	236	236	236	236	236
	TotalMHL	236	236	236	236	236

Table 28: Multiple regression model summary^b for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.660 ^a	.435	.425	6.05256

a. Predictors: (Constant), TotalMHL, TotalNBstigma, TotalCBhelp, TotalBBscore

b. Dependent Variable: TotalHSmhp

Table 29: ANOVA data^a for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	6514.205	4	1628.551	44.455	.000 ^b
	Residual	8462.338	231	36.633		
	Total	14976.542	235			

a. Dependent Variable: TotalHSmhp

b. Predictors: (Constant), TotalMHL, TotalNBstigma, TotalCBhelp, TotalBBscore

Table 30: Coefficients^a for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Model		Unstandardized Coefficients		Standardized Coefficients	t	Sig.
		B	Std. Error	Beta		
1	(Constant)	-.779	5.787		-.135	.893
	TotalBBscore	.346	.132	.133	2.613	.010
	TotalNBstigma	-.069	.089	-.039	-.780	.436
	TotalCBhelp	.586	.048	.620	12.172	.000
	TotalMHL	-.033	.165	-.010	-.199	.843

Table 31: Coefficients^a cont. for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Model		95.0% Confidence Interval for B		Correlations		
		Lower Bound	Upper Bound	Zero-order	Partial	Part
1	(Constant)	-12.182	10.624			
	TotalBBscore	.085	.607	.264	.169	.129
	TotalNBstigma	-.244	.106	-.030	-.051	-.039
	TotalCBhelp	.492	.681	.644	.625	.602
	TotalMHL	-.358	.293	.066	-.013	-.010

Table 32: Coefficients^a cont. for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Collinearity Statistics			
Model		Tolerance	VIF
1	(Constant)		
	TotalBBscore	.943	1.060
	TotalNBstigma	.984	1.017
	TotalCBhelp	.944	1.059
	TotalMHL	.986	1.014

a. Dependent Variable: TotalHSmhp

Table 33: Collinearity diagnostics for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Model	Dimension	Eigenvalue	Condition Index	Variance Proportions		
				(Constant)	TotalBBscore	TotalNBstigma
1	1	4.851	1.000	.00	.00	.00
	2	.115	6.491	.00	.00	.01
	3	.016	17.283	.00	.45	.42
	4	.014	18.681	.00	.23	.11
	5	.003	37.545	1.00	.32	.46

Table 34: Collinearity diagnostics cont. for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Variance Proportions			
Model	Dimension	TotalCBhelp	TotalMHL
1	1	.01	.00
	2	.97	.01
	3	.02	.01
	4	.00	.70
	5	.01	.29

a. Dependent Variable: TotalHSmhp

Table 35: Casewise diagnostics^a for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

Case Number	Std. Residual	TotalHSmhp	Predicted Value	Residual
34	3.927	32.00	8.2317	23.76827
168	-3.030	6.00	24.3375	-18.33747

a. Dependent Variable: TotalHSmhp

Table 36: Residuals statistics^a for aims 8-9 – how well is the TPB model able to predict professional help-seeking intentions in men? Is the predictive accuracy of the TPB model improved by adding the MHL variable to the model?

	Minimum	Maximum	Mean	Std. Deviation	N
Predicted Value	2.6653	27.2928	16.2203	5.26498	236
Std. Predicted Value	-2.575	2.103	.000	1.000	236
Standard Error of Predicted Value	.420	1.889	.842	.260	236
Adjusted Predicted Value	2.3055	27.1400	16.2196	5.26941	236
Residual	-18.33747	23.76827	.00000	6.00083	236
Std. Residual	-3.030	3.927	.000	.991	236
Stud. Residual	-3.086	3.966	.000	1.002	236
Deleted Residual	-19.02681	24.24666	.00078	6.13537	236
Stud. Deleted Residual	-3.145	4.100	.000	1.009	236
Mahal. Distance	.138	21.887	3.983	3.402	236
Cook's Distance	.000	.096	.005	.010	236
Centered Leverage Value	.001	.093	.017	.014	236

a. Dependent Variable: TotalHSmhp

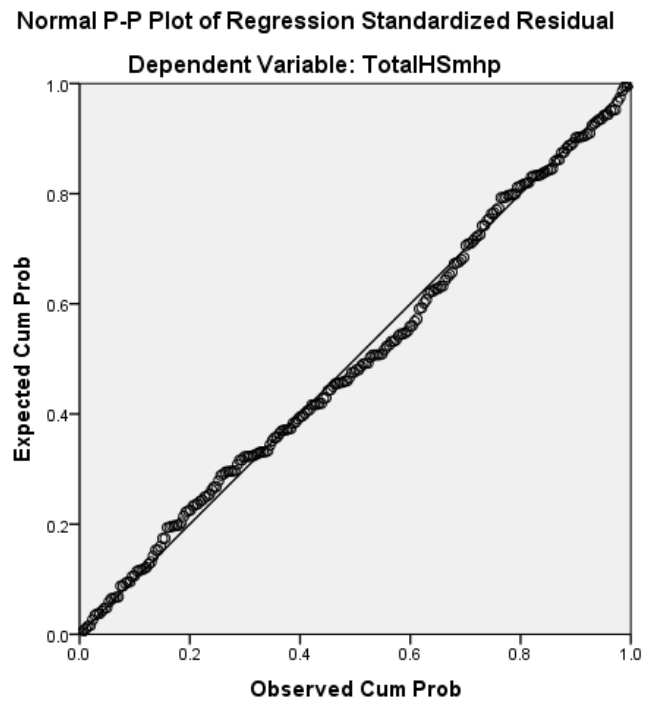


Figure 8: Standardised residual plot for multiple regression for aims 8&9

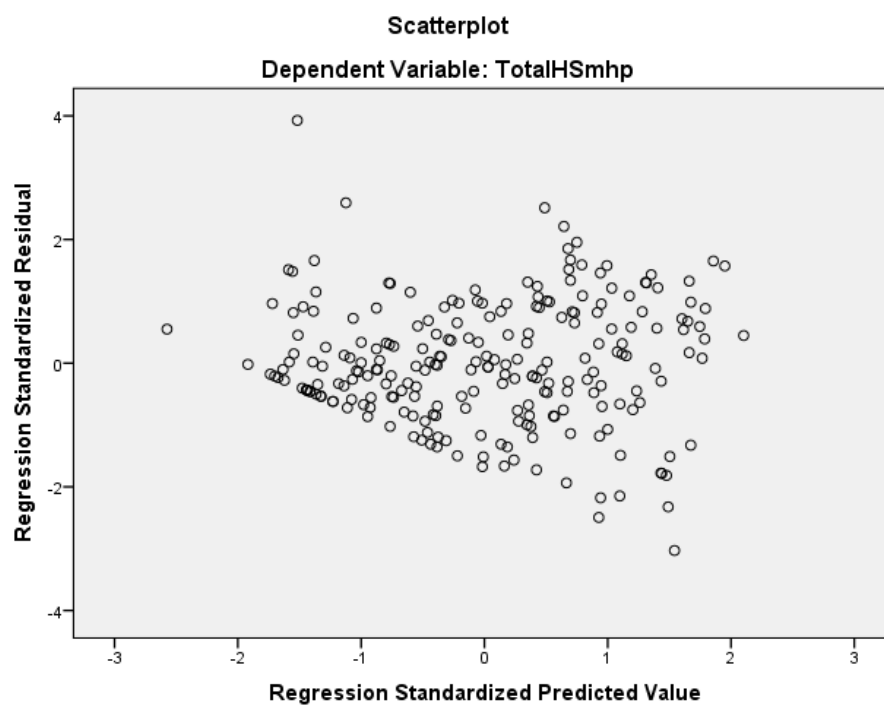


Figure 9: Scatter plot for multiple regression for aims 8&9